DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 414, 415, 485, and 498

[CMS–1413–FC]

RINs 0938–AP40

Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period implements changes to the physician fee schedule and other Medicare Part B payment policies to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. It also implements or discusses certain provisions of the Medicare Improvements for Patients and Providers Act of 2008. (See the Table of Contents for a listing of the specific issues addressed in this rule.)

This final rule with comment period also finalizes the calendar year (CY) 2009 interim relative value units (RVUs) and issues interim RVUs for new and revised codes for CY 2010. In addition, in accordance with the statute, it announces that the update to the physician fee schedule conversion factor is −21.2 percent for CY 2010, the preliminary estimate for the sustainable growth rate for CY 2010 is −8.8 percent, and the conversion factor (CF) for CY 2010 is $28.4061.

DATES: *Effective Dates:* With the exception of the provisions of § 414.68 and § 414.210(e)(5), this final rule is effective on January 1, 2010. The provisions of § 414.68 are effective on October 30, 2009, and the provisions of § 414.210(e)(5) are effective on July 1, 2010.

Comment Date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on December 29, 2009.

ADDRESSES: In commenting, please refer to file code CMS–1413–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically*. You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instructions under the ''More Search Options'' tab.

2. *By regular mail*. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1413–FC, P.O. Box 8013, Baltimore, MD 21244–8013.

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

3. *By express or overnight mail*. You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1413–FC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

a. For delivery in Washington, DC—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(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 a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

FOR FURTHER INFORMATION CONTACT: Rick Ensor, (410) 786–5617, for issues related to practice expense methodology.

Craig Dobyski, (410) 786–4584, for issues related to geographic practice cost indices and malpractice RVUs.

Ken Marsalek, (410) 786–4502, for issues related to the physician practice information survey and the multiple procedure payment reduction.

Regina Walker-Wren, (410) 786–9160, for issues related to the phasing out of the outpatient mental health treatment limitation.

Diane Stern, (410) 786–1133, for issues related to the physician quality reporting initiative and incentives for e-prescribing.

Lisa Grabert, (410) 786–6827, for issues related to the Physician Resource Use Feedback Program.

Colleen Bruce, (410) 786–5529, for issues related to value-based purchasing.

Sandra Bastinelli, (410) 786–3630, for issues related to the implementation of accreditation standards.

Jim Menas, (410) 786–4507, for issues related to teaching anesthesia services.

Sarah McClain, (410) 786–2994, for issues related to the coverage of cardiac rehabilitation services.

Dorothy Shannon, (410) 786–3396, for issues related to payment for cardiac and pulmonary rehabilitation services.

Roya Lotfi, (410) 786–4072, for issues related to the coverage of pulmonary rehabilitation.

Jamie Hermansen, (410) 786–2064, for issues related to kidney disease patient education programs.

Terri Harris, (410) 786–6830, for issues related to payment for kidney disease patient education.

Brijet Burton, (410) 786–7364, for issues related to the compendia for determination of medically-accepted indications for off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen.

Henry Richter, (410) 786–4562, or Lisa Hubbard, (410) 786–5472, for issues related to renal dialysis provisions and payments for end-stage renal disease facilities.

Cheryl Gilbreath, (410) 786–5919, for issues related to payment for covered outpatient drugs and biologicals.

Edmund Kasaitis, (410) 786–0477, or Bonny Dahm, (410) 786–4006, for issues related to the Competitive Acquisition Program (CAP) for Part B drugs.

Pauline Lapin, (410) 786–6883, for issues related to the chiropractic services demonstration BN issue.

Monique Howard, (410) 786–3869, for issues related to CORF conditions of coverage.

Roechel Kujawa, (410) 786–9111, for issues related to ambulance services.

Anne Tayloe Hauswald, (410) 786–4546, for clinical laboratory issues.

Troy Barsky, (410) 786–8873, or Roy Albert, (410) 786–1872, for issues related to physician self-referral.

Christopher Molling, (410) 786–6399, or Anita Greenberg, (410) 786–4601, for issues related to the repeal of transfer of title for oxygen equipment.

Michelle Peterman, (410) 786–2591, or Iffat Fatima, (410) 786–6709 for issues related to the grandfathering provisions of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Competitive Acquisition Program.

Ralph Goldberg, (410) 786–4870, or Heidi Edmunds, (410) 786–1781, for issues related to the damages process caused by the termination of contracts awarded in 2008 under the DMEPOS Competitive Bidding program.

Diane Milstead, (410) 786–3355, or Gaysha Brooks, (410) 786–9649, for all other issues.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on the following issues: interim relative value units (RVUs) for selected codes identified in Addendum C; the physician self-referral designated health services (DHS) codes listed in Tables 31 and 32; services for consideration for the Five-Year Review of work RVUs for services as discussed in section II.P., and information concerning services provided under arrangement as discussed in section II.N.2.

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

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

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Acronyms

In addition, because of the many organizations and terms to which we refer by acronym in this final rule with comment period, we are listing these acronyms and their corresponding terms in alphabetical order below:

AA Anesthesiologist assistant
AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation
AANA American Association of Nurse Anesthetists
ABMS American Board of Medical Specialties
ABN Advanced Beneficiary Notice
ACC American College of Cardiology
ACGME Accreditation Council on Graduate Medical Education
ACLS Advanced cardiac life support
ACR American College of Radiology
AED Automated external defibrillator
AFROC Association of Freestanding Radiation Oncology Centers
AHA American Heart Association
AHFS–DI American Hospital Formulary Service—Drug Information
AHRQ [HHS'] Agency for Healthcare Research and Quality
AMA American Medical Association
AMA–DE American Medical Association Drug Evaluations
AMP Average manufacturer price
AO Accreditation organization
AOA American Osteopathic Association
APA American Psychological Association
APTA American Physical Therapy Association
ARRA American Recovery and Reinvestment Act (Pub. L. 111–5)
ASC Ambulatory surgical center
ASP Average sales price
ASRT American Society of Radiologic Technologists
ASTRO American Society for Therapeutic Radiology and Oncology
ATA American Telemedicine Association
AWP Average wholesale price
BBA Balanced Budget Act of 1997 (Pub. L. 105–33)
BBRA [Medicare, Medicaid and State Child Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113)
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000 (Pub. L. 106–554)
BLS Basic Life support
BN Budget neutrality
BPM Benefit Policy Manual
CABG Coronary artery bypass graft
CAD Coronary artery disease
CAH Critical access hospital
CAHEA Committee on Allied Health Education and Accreditation
CAP Competitive acquisition program
CBIC Competitive Bidding Implementation Contractor
CBP Competitive Bidding Program
CBSA Core-Based Statistical Area
CF Conversion factor
CfC Conditions for Coverage
CFR Code of Federal Regulations
CKD Chronic kidney disease
CLFS Clinical laboratory fee schedule
CMA California Medical Association
CMHC Community mental health center
CMP Civil money penalty
CMS Centers for Medicare & Medicaid Services
CNS Clinical nurse specialist
CoP Condition of participation
COPD Chronic obstructive pulmonary disease
CORF Comprehensive Outpatient Rehabilitation Facility
COS Cost of service
CPEP Clinical Practice Expert Panel
CPI Consumer Price Index
CPI–U Consumer price index for urban customers
CPR Cardiopulmonary resuscitation
CPT [Physicians'] Current Procedural Terminology (4th Edition, 2002, copyrighted by the American Medical Association)
CR Cardiac rehabilitation
CRNA Certified registered nurse anesthetist
CRP Canalith repositioning
CRT Certified respiratory therapist
CSW Clinical social worker
CY Calendar year
DEA Drug Enforcement Agency
DHS Designated health services
DME Durable medical equipment
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DOQ Doctor's Office Quality
DOS Date of service
DRA Deficit Reduction Act of 2005 (Pub. L. 109–171)

DSMT Diabetes self-management training
E/M Evaluation and management
EDI Electronic data interchange
EEG Electroencephalogram
EHR Electronic health record
EKG Electrocardiogram
EMG Electromyogram
EMTALA Emergency Medical Treatment and Active Labor Act
EOG Electro-oculogram
EPO Erythopoeitin
ESRD End-stage renal disease
FAX Facsimile
FDA Food and Drug Administration (HHS)
FFS Fee-for-service
FR **Federal Register**
GAF Geographic adjustment factor
GAO General Accounting Office
GEM Generating Medicare [Physician Quality Performance Measurement Results]
GFR Glomerular filtration rate
GPO Group purchasing organization
GPCI Geographic practice cost index
HAC Hospital-acquired conditions
HBAI Health and behavior assessment and intervention
HCPAC Health Care Professional Advisory Committee
HCPCS Healthcare Common Procedure Coding System
HCRIS Healthcare Cost Report Information System
HDRT High dose radiation therapy
HH PPS Home Health Prospective Payment System
HHA Home health agency
HHRG Home health resource group
HHS [Department of] Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
HIT Health information technology
HITECH Health Information Technology for Economic and Clinical Health Act (Title IV of Division B of the Recovery Act, together with Title XIII of Division A of the Recovery Act)
HITSP Healthcare Information Technology Standards Panel
HIV Human immunodeficiency virus
HOPD Hospital outpatient department
HPSA Health Professional Shortage Area
HRSA Health Resources Services Administration (HHS)
IACS Individuals Access to CMS Systems
ICD International Classification of Diseases
ICF Intermediate care facilities
ICR Intensive cardiac rehabilitation
ICR Information collection requirement
IDTF Independent diagnostic testing facility
IFC Interim final rule with comment period
IMRT Intensity-Modulated Radiation Therapy
IPPE Initial preventive physical examination
IPPS Inpatient prospective payment system
IRS Internal Revenue Service
ISO Insurance services office
IVD Ischemic Vascular Disease
IVIG Intravenous immune globulin
IWPUT Intra-service work per unit of time
JRCERT Joint Review Committee on Education in Radiologic Technology
KDE Kidney disease education
LCD Local coverage determination
MA Medicare Advantage
MA–PD Medicare Advantage—Prescription Drug Plans
MAV Measure Applicability Validation
MCMP Medicare Care Management Performance
MDRD Modification of Diet in Renal Disease
MedCAC Medicare Evidence Development and Coverage Advisory Committee (formerly the Medicare Coverage Advisory Committee (MCAC))
MedPAC Medicare Payment Advisory Commission
MEI Medicare Economic Index
MIEA–TRHCA Medicare Improvements and Extension Act of 2006 (that is, Division B of the Tax Relief and Health Care Act of 2006 (TRHCA) (Pub. L. 109–432)
MIPPA Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275)
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173)
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173)
MNT Medical nutrition therapy
MOC Maintenance of certification
MP Malpractice
MPPR Multiple procedure payment reduction
MQSA Mammography Quality Standards Act of 1992 (Pub. L. 102–539)
MRA Magnetic resonance angiography
MRI Magnetic resonance imaging
MSA Metropolitan statistical area
NBRC National Board for Respiratory Care
NCD National Coverage Determination
NCQDIS National Coalition of Quality Diagnostic Imaging Services
NDC National drug code
NF Nursing facility
NISTA National Institute of Standards and Technology Act
NP Nurse practitioner
NPI National Provider Identifier
NPP Nonphysician practitioner
NQF National Quality Forum
NRC Nuclear Regulatory Commission
OACT [CMS'] Office of the Actuary
OBRA Omnibus Budget Reconciliation Act
ODF Open door forum
OGPE Oxygen generating portable equipment
OIG Office of Inspector General
OMB Office of Management and Budget
ONC [HHS'] Office of the National Coordinator for Health IT
OPPS Outpatient prospective payment system
OSCAR Online Survey and Certification and Reporting
PA Physician assistant
PAT Performance assessment tool
PC Professional component
PCI Percutaneous coronary intervention
PDP Prescription drug plan
PE Practice expense
PE/HR Practice expense per hour
PEAC Practice Expense Advisory Committee
PERC Practice Expense Review Committee
PFS Physician Fee Schedule
PGP [Medicare] Physician Group Practice
PHI Protected health information
PHP Partial hospitalization program
PIM [Medicare] Program Integrity Manual
PLI Professional liability insurance
POA Present on admission
POC Plan of care
PPI Producer price index
PPIS Physician Practice Information Survey
PPS Prospective payment system
PPTA Plasma Protein Therapeutics Association
PQRI Physician Quality Reporting Initiative
PR Pulmonary rehabilitation
PRA Paperwork Reduction Act
PSA Physician scarcity areas
PT Physical therapy
PTCA Percutaneous transluminal coronary angioplasty
PVBP Physician and Other Health Professional Value-Based Purchasing Workgroup
RA Radiology assistant
RBMA Radiology Business Management Association
RFA Regulatory Flexibility Act
RHC Rural health clinic
RIA Regulatory impact analysis
RN Registered nurse
RNAC Reasonable net acquisition cost
RPA Radiology practitioner assistant
RRT Registered respiratory therapist
RUC [AMA's Specialty Society] Relative (Value) Update Committee
RVU Relative value unit
SBA Small Business Administration
SGR Sustainable growth rate
SLP Speech-language pathology
SMS [AMA's] Socioeconomic Monitoring System
SNF Skilled nursing facility
SOR System of record
SRS Stereotactic radiosurgery
STARS Services Tracking and Reporting System
TC Technical Component
TIN Tax identification number
TRHCA Tax Relief and Health Care Act of 2006 (Pub. L. 109–432)
TTO Transtracheal oxygen
UPMC University of Pittsburgh Medical Center
USDE United States Department of Education
USP–DI United States Pharmacopoeia—Drug Information
VBP Value-based purchasing
WAMP Widely available market price

I. Background

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), ''Payment for Physicians' Services.'' The Act requires that payments under the physician fee schedule (PFS) are based on national uniform relative value units (RVUs) based on the relative resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense (PE), and malpractice expense. Before the establishment of the resource-based relative value system, Medicare payment for physicians'

services was based on reasonable charges.

A. Development of the Relative Value System

1. Work RVUs

The concepts and methodology underlying the PFS were enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (Pub. L. 101–239), and OBRA 1990, (Pub. L. 101–508). The final rule, published on November 25, 1991 (56 FR 59502), set forth the fee schedule for payment for physicians' services beginning January 1, 1992. Initially, only the physician work RVUs were resource-based, and the PE and malpractice RVUs were based on average allowable charges.

The physician work RVUs established for the implementation of the fee schedule in January 1992 were developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original physician work RVUs for most codes in a cooperative agreement with the Department of Health and Human Services (DHHS). In constructing the code-specific vignettes for the original physician work RVUs, Harvard worked with panels of experts, both inside and outside the Federal government, and obtained input from numerous physician specialty groups.

Section 1848(b)(2)(B) of the Act specifies that the RVUs for anesthesia services are based on RVUs from a uniform relative value guide, with appropriate adjustment of the conversion factor (CF), in a manner to assure that fee schedule amounts for anesthesia services are consistent with those for other services of comparable value. We established a separate CF for anesthesia services, and we continue to utilize time units as a factor in determining payment for these services. As a result, there is a separate payment methodology for anesthesia services.

We establish physician work RVUs for new and revised codes based on our review of recommendations received from the American Medical Association's (AMA) Specialty Society Relative Value Update Committee (RUC).

2. Practice Expense Relative Value Units (PE RVUs)

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, amended section 1848(c)(2)(C)(ii) of the Act and required us to develop resource-based PE RVUs for each physician's service beginning in 1998. We were to consider general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising PEs.

Section 4505(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), amended section 1848(c)(2)(C)(ii) of the Act to delay implementation of the resource-based PE RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from charge-based PE RVUs to resource-based RVUs.

We established the resource-based PE RVUs for each physicians' service in a final rule, published November 2, 1998 (63 FR 58814), effective for services furnished in 1999. Based on the requirement to transition to a resource-based system for PE over a 4-year period, resource-based PE RVUs did not become fully effective until 2002.

This resource-based system was based on two significant sources of actual PE data: the Clinical Practice Expert Panel (CPEP) data; and the AMA's Socioeconomic Monitoring System (SMS) data. The CPEP data were collected from panels of physicians, practice administrators, and nonphysicians (for example, registered nurses (RNs)) nominated by physician specialty societies and other groups. The CPEP panels identified the direct inputs required for each physician's service in both the office setting and out-of-office setting. We have since refined and revised these inputs based on recommendations from the RUC. The AMA's SMS data provided aggregate specialty-specific information on hours worked and PEs.

Separate PE RVUs are established for procedures that can be performed in both a nonfacility setting, such as a physician's office, and a facility setting, such as a hospital outpatient department. The difference between the facility and nonfacility RVUs reflects the fact that a facility typically receives separate payment from Medicare for its costs of providing the service, apart from payment under the PFS. The nonfacility RVUs reflect all of the direct and indirect PEs of providing a particular service.

Section 212 of the Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) directed the Secretary of Health and Human Services (the Secretary) to establish a process under which we accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations to supplement the data we normally collect in determining the PE component. On May 3, 2000, we published the interim final rule (65 FR 25664) that set forth the criteria for the submission of these supplemental PE survey data. The criteria were modified in response to comments received, and published in the **Federal Register** (65 FR 65376) as part of a November 1, 2000 final rule. The PFS final rules published in 2001 and 2003, respectively, (66 FR 55246 and 68 FR 63196) extended the period during which we would accept these supplemental data through March 1, 2005.

In the Calendar Year (CY) 2007 PFS final rule with comment period (71 FR 69624), we revised the methodology for calculating PE RVUs beginning in CY 2007 and provided for a 4-year transition for the new PE RVUs under this new methodology.

3. Resource-Based Malpractice (MP) RVUs

Section 4505(f) of the BBA amended section 1848(c) of the Act requiring us to implement resource-based malpractice (MP) RVUs for services furnished on or after 2000. The resource-based MP RVUs were implemented in the PFS final rule published November 2, 1999 (64 FR 59380). The MP RVUs were based on malpractice insurance premium data collected from commercial and physician-owned insurers from all the States, the District of Columbia, and Puerto Rico.

4. Refinements to the RVUs

Section 1848(c)(2)(B)(i) of the Act requires that we review all RVUs no less often than every 5 years. The first Five-Year Review of the physician work RVUs was published on November 22, 1996 (61 FR 59489) and was effective in 1997. The second Five-Year Review was published in the CY 2002 PFS final rule with comment period (66 FR 55246) and was effective in 2002. The third Five-Year Review of physician work RVUs was published in the CY 2007 PFS final rule with comment period (71 FR 69624) and was effective on January 1, 2007. (**Note:** Additional codes relating to the third Five-Year Review of physician work RVUs were addressed in the CY 2008 PFS final rule with comment period (72 FR 66360).)

In 1999, the AMA's RUC established the Practice Expense Advisory Committee (PEAC) for the purpose of refining the direct PE inputs. Through March 2004, the PEAC provided recommendations to CMS for over 7,600 codes (all but a few hundred of the codes currently listed in the AMA's Current Procedural Terminology (CPT) codes). As part of the CY 2007 PFS final rule with comment period (71 FR 69624), we implemented a new

methodology for determining resource-based PE RVUs and are transitioning it over a 4-year period.

In the CY 2005 PFS final rule with comment period (69 FR 66236), we implemented the first Five-Year Review of the MP RVUs (69 FR 66263).

5. Adjustments to RVUs Are Budget Neutral

Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs for a year may not cause total PFS payments to differ by more than $20 million from what they would have been if the adjustments were not made. In accordance with section 1848(c)(2)(B)(ii)(II) of the Act, if revisions to the RVUs cause expenditures to change by more than $20 million, we make adjustments to ensure that expenditures do not increase or decrease by more than $20 million.

As explained in the CY 2009 PFS final rule with comment period (73FR 69730), as required by section 133(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275), the separate budget neutrality (BN) adjustor resulting from the third Five-Year Review of physician work RVUs is being applied to the CF beginning with CY 2009 rather than the work RVUs.

B. Components of the Fee Schedule Payment Amounts

To calculate the payment for every physicians' service, the components of the fee schedule (physician work, PE, and MP RVUs) are adjusted by a geographic practice cost index (GPCI). The GPCIs reflect the relative costs of physician work, PE, and malpractice expense in an area compared to the national average costs for each component.

RVUs are converted to dollar amounts through the application of a CF, which is calculated by CMS' Office of the Actuary (OACT).

The formula for calculating the Medicare fee schedule payment amount for a given service and fee schedule area can be expressed as:

Payment = [(RVU work × GPCI work) + (RVU PE × GPCI PE) + (RVU malpractice × GPCI malpractice)] × CF.

C. Most Recent Changes to the Fee Schedule

The CY 2009 PFS final rule with comment period (73 FR 69726) implemented changes to the PFS and other Medicare Part B payment policies. It also finalized the CY 2008 interim RVUs and implemented interim RVUs for new and revised codes for CY 2009 to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. The CY 2009 PFS final rule with comment period also addressed other policies, as well as certain provisions of the MIPPA.

As required by the statute, and based on section 131 of the MIPPA, the CY 2009 PFS final rule with comment period also announced the following for CY 2009: the PFS update of 1.1 percent, the initial estimate for the sustainable growth rate of 7.4 percent, and the conversion factor (CF) of $36.0666.

II. Provisions of the Final Regulation

In response to the CY 2010 PFS proposed rule (74 FR 33520) we received approximately 16,500 timely public comments. These included comments from concerned citizens, individual physicians, health care workers, professional associations and societies, manufacturers and Congressmen. The majority of the comments addressed proposals related to the MIPPA provisions concerning teaching anesthesiology and cardiac and pulmonary rehabilitation, the physician practice information survey (PPIS), and the impact of the proposed rule on specific specialties. To the extent that comments were outside the scope of the proposed rule, they are not addressed in this final rule with comment period.

A. Resource-Based Practice Expense (PE) Relative Value Units (RVUs)

Practice expense (PE) is the portion of the resources used in furnishing the service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages but excluding malpractice expenses, as specified in section 1848(c)(1)(B) of the Act.

Section 121 of the Social Security Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, required CMS to develop a methodology for a resource-based system for determining PE RVUs for each physician's service. Until that time, PE RVUs were based on historical allowed charges. This legislation stated that the revised PE methodology must consider the staff, equipment, and supplies used in the provision of a variety of medical and surgical services in various settings beginning in 1998. The Secretary has interpreted this to mean that Medicare payments for each service would be based on the relative PE resources typically involved with furnishing the service.

The initial implementation of resource-based PE RVUs was delayed from January 1, 1998, until January 1, 1999, by section 4505(a) of the BBA. In addition, section 4505(b) of the BBA required that the new payment methodology be phased in over 4 years, effective for services furnished in CY 1999, and fully effective in CY 2002. The first step toward implementation of the statute was to adjust the PE values for certain services for CY 1998. Section 4505(d) of the BBA required that, in developing the resource-based PE RVUs, the Secretary must—

- Use, to the maximum extent possible, generally-accepted cost accounting principles that recognize all staff, equipment, supplies, and expenses, not solely those that can be linked to specific procedures and actual data on equipment utilization.
- Develop a refinement method to be used during the transition.
- Consider, in the course of notice and comment rulemaking, impact projections that compare new proposed payment amounts to data on actual physician PE.

In CY 1999, we began the 4-year transition to resource-based PE RVUs utilizing a ''top-down'' methodology whereby we allocated aggregate specialty-specific practice costs to individual procedures. The specialty-specific PEs were derived from the American Medical Association's (AMA's) Socioeconomic Monitoring Survey (SMS). In addition, under section 212 of the BBRA, we established a process extending through March 2005 to supplement the SMS data with data submitted by a specialty. The aggregate PEs for a given specialty were then allocated to the services furnished by that specialty on the basis of the direct input data (that is, the staff time, equipment, and supplies) and work RVUs assigned to each CPT code.

For CY 2007, we implemented a new methodology for calculating PE RVUs. Under this new methodology, we use the same data sources for calculating PE, but instead of using the ''top-down'' approach to calculate the direct PE RVUs, under which the aggregate direct and indirect costs for each specialty are allocated to each individual service, we now utilize a ''bottom-up'' approach to calculate the direct costs. Under the ''bottom up'' approach, we determine the direct PE by adding the costs of the resources (that is, the clinical staff, equipment, and supplies) typically required to provide each service. The costs of the resources are calculated using the refined direct PE inputs assigned to each CPT code in our PE database, which are based on our review of recommendations received from the AMA's Relative Value Update Committee (RUC). For a more detailed

explanation of the PE methodology, see the Five-Year Review of Work Relative Value Units Under the PFS and Proposed Changes to the Practice Expense Methodology proposed notice (71 FR 37242) and the CY 2007 PFS final rule with comment period (71 FR 69629).

Note: In section II.A.1 of this final rule with comment period rule, we discuss the current methodology used for calculating PE. In section II.A.2. of this final rule with comment period, which contains PE proposals for CY 2010, we summarize and respond to comments on our proposal to use data from the AMA Physician Practice Information Survey (PPIS) in place of the AMA's SMS survey data and supplemental survey data that is currently used in the PE methodology, as well as our proposal concerning equipment utilization assumptions.

1. Practice Expense Methodology

a. Data Sources for Calculating Practice Expense

The AMA's SMS survey data and supplemental survey data from the specialties of cardiothoracic surgery, vascular surgery, physical and occupational therapy, independent laboratories, allergy/immunology, cardiology, dermatology, gastroenterology, radiology, independent diagnostic testing facilities (IDTFs), radiation oncology, and urology are currently used to develop the PE per hour (PE/HR) for each specialty. For those specialties for which we do not have PE/HR, the appropriate PE/HR is obtained from a crosswalk to a similar specialty.

The AMA developed the SMS survey in 1981 and discontinued it in 1999. Beginning in 2002, we incorporated the 1999 SMS survey data into our calculation of the PE RVUs, using a 5-year average of SMS survey data. (See the CY 2002 PFS final rule with comment period (66 FR 55246).) The SMS PE survey data are adjusted to a common year, 2005. The SMS data provide the following six categories of PE costs:

- Clinical payroll expenses, which are payroll expenses (including fringe benefits) for nonphysician clinical personnel.
- Administrative payroll expenses, which are payroll expenses (including fringe benefits) for nonphysician personnel involved in administrative, secretarial, or clerical activities.
- Office expenses, which include expenses for rent, mortgage interest, depreciation on medical buildings, utilities, and telephones.
- Medical material and supply expenses, which include expenses for drugs, x-ray films, and disposable medical products.
- Medical equipment expenses, which include depreciation, leases, and rent of medical equipment used in the diagnosis or treatment of patients.
- All other expenses, which include expenses for legal services, accounting, office management, professional association memberships, and any professional expenses not previously mentioned in this section.

In accordance with section 212 of the BBRA, we established a process to supplement the SMS data for a specialty with data collected by entities and organizations other than the AMA (that is, those entities and organizations representing the specialty itself). (See the Criteria for Submitting Supplemental Practice Expense Survey Data interim final rule with comment period (65 FR 25664).) Originally, the deadline to submit supplementary survey data was through August 1, 2001. In the CY 2002 PFS final rule (66 FR 55246), the deadline was extended through August 1, 2003. To ensure maximum opportunity for specialties to submit supplementary survey data, we extended the deadline to submit surveys until March 1, 2005 in the Revisions to Payment Policies Under the Physician Fee Schedule for CY 2004 final rule with comment period (68 FR 63196) (hereinafter referred to as CY 2004 PFS final rule with comment period).

The direct cost data for individual services were originally developed by the Clinical Practice Expert Panels (CPEP). The CPEP data include the supplies, equipment, and staff times specific to each procedure. The CPEPs consisted of panels of physicians, practice administrators, and nonphysicians (for example, RNs) who were nominated by physician specialty societies and other groups. There were 15 CPEPs consisting of 180 members from more than 61 specialties and subspecialties. Approximately 50 percent of the panelists were physicians.

The CPEPs identified specific inputs involved in each physician's service provided in an office or facility setting. The inputs identified were the quantity and type of nonphysician labor, medical supplies, and medical equipment. The CPEP data has been regularly updated by various RUC committees on PE.

b. Allocation of PE to Services

Currently, the aggregate level specialty-specific PEs are derived from the AMA's SMS survey and supplementary survey data. For CY 2010, we discuss in section II.A.2. of this final rule with comment period how a new data source, PPIS, will be used. To establish PE RVUs for specific services, it is necessary to establish the direct and indirect PE associated with each service.

(i) *Direct costs.* The direct costs are determined by adding the costs of the resources (that is, the clinical staff, equipment, and supplies) typically required to provide the service. The costs of these resources are calculated from the refined direct PE inputs in our PE database. These direct inputs are then scaled to the current aggregate pool of direct PE RVUs. The aggregate pool of direct PE RVUs can be derived using the following formula: (PE RVUs × physician CF) × (average direct percentage from survey PE/HR data)).

(ii) *Indirect costs.* Currently, the SMS and supplementary survey data are the sources for the specialty-specific aggregate indirect costs used in our PE calculations. For CY 2010, we discuss in section II.A.2. of this final rule with comment period how a new data source, PPIS, will be used. We then allocate the indirect costs to the code level on the basis of the direct costs specifically associated with a code and the greater of either the clinical labor costs or the physician work RVUs. For calculation of the 2010 PE RVUs, we use the 2008 procedure-specific utilization data crosswalked to 2010 services. To arrive at the indirect PE costs—

- We apply a specialty-specific indirect percentage factor to the direct expenses to recognize the varying proportion that indirect costs represent of total costs by specialty. For a given service, the specific indirect percentage factor to apply to the direct costs for the purpose of the indirect allocation is calculated as the weighted average of the ratio of the indirect to direct costs (based on the survey data) for the specialties that furnish the service. For example, if a service is furnished by a single specialty with indirect PEs that were 75 percent of total PEs, the indirect percentage factor to apply to the direct costs for the purposes of the indirect allocation would be (0.75/0.25) = 3.0. The indirect percentage factor is then applied to the service level adjusted indirect PE allocators.
- We currently use the specialty-specific PE/HR from the SMS survey data, as well as the supplemental surveys for cardiothoracic surgery, vascular surgery, physical and occupational therapy, independent laboratories, allergy/immunology, cardiology, dermatology, radiology, gastroenterology, IDTFs, radiation oncology, and urology. (**Note:** For radiation oncology, the data represent the combined survey data from the

American Society for Therapeutic Radiology and Oncology (ASTRO) and the Association of Freestanding Radiation Oncology Centers (AFROC)). As discussed in the CY 2008 PFS final rule with comment period (72 FR 66233), the PE/HR survey data for radiology is weighted by practice size. For CY 2010, we discuss in section II.A.2. of this final rule with comment period how a new data source, PPIS, will be used. We incorporate this PE/HR into the calculation of indirect costs using an index which reflects the relationship between each specialty's indirect scaling factor and the overall indirect scaling factor for the entire PFS. For example, if a specialty had an indirect practice cost index of 2.00, this specialty would have an indirect scaling factor that was twice the overall average indirect scaling factor. If a specialty had an indirect practice cost index of 0.50, this specialty would have an indirect scaling factor that was half the overall average indirect scaling factor.

- When the clinical labor portion of the direct PE RVU is greater than the physician work RVU for a particular service, the indirect costs are allocated based upon the direct costs and the clinical labor costs. For example, if a service has no physician work and 1.10 direct PE RVUs, and the clinical labor portion of the direct PE RVUs is 0.65 RVUs, we would use the 1.10 direct PE RVUs and the 0.65 clinical labor portions of the direct PE RVUs to allocate the indirect PE for that service.

c. Facility and Non-Facility Costs

Procedures that can be furnished in a physician's office, as well as in a hospital or facility setting have two PE RVUs: facility and non-facility. The non-facility setting includes physicians' offices, patients' homes, freestanding imaging centers, and independent pathology labs. Facility settings include hospitals, ambulatory surgical centers (ASCs), and skilled nursing facilities (SNFs). The methodology for calculating PE RVUs is the same for both facility and non-facility RVUs, but is applied independently to yield two separate PE RVUs. Because the PEs for services provided in a facility setting are generally included in the payment to the facility (rather than the payment to the physician under the PFS), the PE RVUs are generally lower for services provided in the facility setting.

d. Services With Technical Components (TCs) and Professional Components (PCs)

Diagnostic services are generally comprised of two components: a professional component (PC) and a technical component (TC), both of which may be performed independently or by different providers. When services have TCs, PCs, and global components that can be billed separately, the payment for the global component equals the sum of the payment for the TC and PC. This is a result of using a weighted average of the ratio of indirect to direct costs across all the specialties that furnish the global components, TCs, and PCs; that is, we apply the same weighted average indirect percentage factor to allocate indirect expenses to the global components, PCs, and TCs for a service. (The direct PE RVUs for the TC and PC sum to the global under the bottom-up methodology.)

e. Transition Period

As discussed in the CY 2007 PFS final rule with comment period (71 FR 69674), the change to the PE methodology was implemented over a 4-year period. In CY 2010, the transition period for the change to the PE methodology is complete and PE RVUs will be calculated based entirely on the current methodology.

f. PE RVU Methodology

The following is a description of the PE RVU methodology. While there are some changes to the data sources, the methodology remains the same.

(i) Setup File

First, we create a setup file for the PE methodology. The setup file contains the direct cost inputs, the utilization for each procedure code at the specialty and facility/non-facility place of service level, and the specialty-specific survey PE per physician hour data.

(ii) Calculate the Direct Cost PE RVUs

Sum the costs of each direct input.

Step 1: Sum the direct costs of the inputs for each service. The direct costs consist of the costs of the direct inputs for clinical labor, medical supplies, and medical equipment. The clinical labor cost is the sum of the cost of all the staff types associated with the service; it is the product of the time for each staff type and the wage rate for that staff type. The medical supplies cost is the sum of the supplies associated with the service; it is the product of the quantity of each supply and the cost of the supply. The medical equipment cost is the sum of the cost of the equipment associated with the service; it is the product of the number of minutes each piece of equipment is used in the service and the equipment cost per minute. The equipment cost per minute is calculated as described at the end of this section.

Apply a BN adjustment to the direct inputs.

Step 2: Calculate the current aggregate pool of direct PE costs. To do this, multiply the current aggregate pool of total direct and indirect PE costs (that is, the current aggregate PE RVUs multiplied by the CF) by the average direct PE percentage from the SMS and supplementary specialty survey data. For CY 2010, we discuss in section II.A.2. of this final rule with comment period how a new data source, PPIS, will be used.

Step 3: Calculate the aggregate pool of direct costs. To do this, for all PFS services, sum the product of the direct costs for each service from Step 1 and the utilization data for that service.

Step 4: Using the results of Step 2 and Step 3 calculate a direct PE BN adjustment so that the aggregate direct cost pool does not exceed the current aggregate direct cost pool and apply it to the direct costs from Step 1 for each service.

Step 5: Convert the results of Step 4 to an RVU scale for each service. To do this, divide the results of Step 4 by the Medicare PFS CF.

(iii) Create the Indirect PE RVUs

Create indirect allocators.

Step 6: Based on the SMS and supplementary specialty survey data, calculate direct and indirect PE percentages for each physician specialty. For CY 2010, we discuss in section II.A.2. of this final rule with comment period how a new data source, PPIS, will be used.

Step 7: Calculate direct and indirect PE percentages at the service level by taking a weighted average of the results of Step 6 for the specialties that furnish the service. Note that for services with TCs and PCs, we are calculating the direct and indirect percentages across the global components, PCs, and TCs. That is, the direct and indirect percentages for a given service (for example, echocardiogram) do not vary by the PC, TC and global component.

Step 8: Calculate the service level allocators for the indirect PEs based on the percentages calculated in Step 7. The indirect PEs are allocated based on the three components: the direct PE RVU, the clinical PE RVU, and the work RVU.

For most services the indirect allocator is:

*indirect percentage * (direct PE RVU/ direct percentage) + work RVU.*

There are two situations where this formula is modified:

- If the service is a global service (that is, a service with global, professional, and technical components), then the

indirect allocator is: *indirect percentage * (direct PE RVU/direct percentage) + clinical PE RVU + work RVU.*

• If the clinical labor PE RVU exceeds the work RVU (and the service is not a global service), then the indirect allocator is: *indirect percentage * (direct PE RVU/direct percentage) + clinical PE RVU.*

Note: For global services, the indirect allocator is based on both the work RVU and the clinical labor PE RVU. We do this to recognize that, for the professional service, indirect PEs will be allocated using the work RVUs, and for the TC service, indirect PEs will be allocated using the direct PE RVU and the clinical labor PE RVU. This also allows the global component RVUs to equal the sum of the PC and TC RVUs.

For presentation purposes in the examples in the Table 1, the formulas were divided into two parts for each service. The first part does not vary by service and is *the indirect percentage * (direct PE RVU/direct percentage).* The second part is either the work RVU, clinical PE RVU, or both depending on whether the service is a global service and whether the clinical PE RVU exceeds the work RVU (as described earlier in this step.)

Apply a BN adjustment to the indirect allocators.

Step 9: Calculate the current aggregate pool of indirect PE RVUs by multiplying the current aggregate pool of PE RVUs by the average indirect PE percentage from the physician specialty survey data. This is similar to the Step 2 calculation for the direct PE RVUs.

Step 10: Calculate an aggregate pool of indirect PE RVUs for all PFS services by adding the product of the indirect PE allocators for a service from Step 8 and the utilization data for that service. This is similar to the Step 3 calculation for the direct PE RVUs.

Step 11: Using the results of Step 9 and Step 10, calculate an indirect PE adjustment so that the aggregate indirect allocation does not exceed the available aggregate indirect PE RVUs and apply it to indirect allocators calculated in Step 8. This is similar to the Step 4 calculation for the direct PE RVUs.

Calculate the Indirect Practice Cost Index.

Step 12: Using the results of Step 11, calculate aggregate pools of specialty-specific adjusted indirect PE allocators for all PFS services for a specialty by adding the product of the adjusted indirect PE allocator for each service and the utilization data for that service.

Step 13: Using the specialty-specific indirect PE/HR data, calculate specialty-specific aggregate pools of indirect PE for all PFS services for that specialty by adding the product of the indirect PE/HR for the specialty, the physician time for the service, and the specialty's utilization for the service.

Step 14: Using the results of Step 12 and Step 13, calculate the specialty-specific indirect PE scaling factors as under the current methodology.

Step 15: Using the results of Step 14, calculate an indirect practice cost index at the specialty level by dividing each specialty-specific indirect scaling factor by the average indirect scaling factor for the entire PFS.

Step 16: Calculate the indirect practice cost index at the service level to ensure the capture of all indirect costs. Calculate a weighted average of the practice cost index values for the specialties that furnish the service. (**Note:** For services with TCs and PCs, we calculate the indirect practice cost index across the global components, PCs, and TCs. Under this method, the indirect practice cost index for a given service (for example, echocardiogram) does not vary by the PC, TC and global component.)

Step 17: Apply the service level indirect practice cost index calculated in Step 16 to the service level adjusted indirect allocators calculated in Step 11 to get the indirect PE RVU.

(iv) Calculate the Final PE RVUs.

Step 18: Add the direct PE RVUs from Step 6 to the indirect PE RVUs from Step 17.

Step 19: Calculate and apply the final PE BN adjustment by comparing the results of Step 18 to the current pool of PE RVUs. This final BN adjustment is required primarily because certain specialties are excluded from the PE RVU calculation for ratesetting purposes, but all specialties are included for purposes of calculating the final BN adjustment. (See ''Specialties excluded from ratesetting calculation'' below in this section.)

(v) Setup File Information

• *Specialties excluded from ratesetting calculation:* For the purposes of calculating the PE RVUs, we exclude certain specialties such as midlevel practitioners paid at a percentage of the PFS, audiology, and low volume specialties from the calculation. These specialties *are* included for the purposes of calculating the BN adjustment.

• *Crosswalk certain low volume physician specialties:* Crosswalk the utilization of certain specialties with relatively low PFS utilization to the associated specialties.

• *Physical therapy utilization:* Crosswalk the utilization associated with all physical therapy services to the specialty of physical therapy.

• *Identify professional and technical services not identified under the usual TC and 26 modifiers:* Flag the services that are PC and TC services, but do not use TC and 26 modifiers (for example, electrocardiograms). This flag associates the PC and TC with the associated global code for use in creating the indirect PE RVU. For example, the professional service code 93010 is associated with the global code 93000.

• *Payment modifiers:* Payment modifiers are accounted for in the creation of the file. For example, services billed with the assistant at surgery modifier are paid 16 percent of the PFS amount for that service; therefore, the utilization file is modified to only account for 16 percent of any service that contains the assistant at surgery modifier.

• *Work RVUs:* The setup file contains the work RVUs from this proposed rule.

(vi) Equipment cost per minute

The equipment cost per minute is calculated as:

*(1/(minutes per year * usage)) * price * ((interest rate/(1 − (1/((1 + interest rate) ** life of equipment)))) + maintenance)*

Where:

minutes per year = maximum minutes per year if usage were continuous (that is, usage = 1); 150,000 minutes.

usage = equipment utilization assumption; 0.9 for certain expensive diagnostic equipment (see section II.A.2. of this final rule with comment period rule) and 0.5 for others.

price = price of the particular piece of equipment.

interest rate = 0.11.

life of equipment = useful life of the particular piece of equipment.

maintenance = factor for maintenance; 0.05.

Note: To illustrate the PE calculation, in Table 1 we have used the conversion factor (CF) of $28.3769 which is the CF effective January 1, 2010 as published in this final rule with comment period.

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TABLE 1: Calculation of PE RVUs under Methodology for Selected Codes

		Step	Source	Formula	99213 Office visit, est Non-facility	33533 CABG, arterial, single Facility	71020 Chest x-ray Non-facility	71020TC Chest x-ray Non-facility	7102026 Chest x-ray Non-facility	93000 ECG, complete Non-facility	93005 ECG, tracing Non-facility	93010 ECG, report Non-facility
1	Labor cost (Lab)	Step 1	AMA		13.32	77.52	5.74	5.74	0.00	6.12	6.12	0.00
2	Supply cost (Sup)	Step 1	AMA		2.98	7.34	3.39	3.39	0.00	1.19	1.19	0.00
3	Equipment cost (Eqp)	Step 1	AMA		0.19	0.65	8.17	8.17	0.00	0.12	0.12	0.00
4	Direct cost (Dir)	Step 1		=(1)+(2)+(3)	16.50	85.51	17.31	17.31	0.00	7.43	7.43	0.00
5	Direct adjustment (Dir Adj)	Steps 2-4	See footnote*		0.508	0.508	0.508	0.508	0.508	0.508	0.508	0.508
6	Adjusted labor	Steps 2-4	=Lab*Dir Adj	=(1)*(5)	6.76	39.35	2.91	2.91	0.00	3.11	3.11	0.00
7	Adjusted supplies	Steps 2-4	=Sup*Dir Adj	=(2)*(5)	1.51	3.73	1.72	1.72	0.00	0.61	0.61	0.00
8	Adjusted equipment	Steps 2-4	=Eqp*Dir Adj	=(3)*(5)	0.10	0.33	4.15	4.15	0.00	0.06	0.06	0.00
9	Adjusted direct	Steps 2-4		=(6)+(7)+(8)	8.38	43.41	8.79	8.79	0.00	3.77	3.77	0.00
10	Conversion Factor (CF)	Step 5	MFS		28.4061	28.4061	28.4061	28.4061	28.4061	28.4061	28.4061	28.4061
11	Adj. labor cost converted	Step 5	=(Lab*Dir Adj)/CF	=(6)/(10)	0.24	1.39	0.10	0.10	0.00	0.11	0.11	0.00
12	Adj. supply cost converted	Step 5	=(Sup*Dir Adj)/CF	=(7)/(10)	0.05	0.13	0.06	0.06	0.00	0.02	0.02	0.00
13	Adj. equip cost converted	Step 5	=(Eqp*Dir Adj)/CF	=(8)/(10)	0.00	0.01	0.15	0.15	0.00	0.00	0.00	0.00
14	Adj. direct cost converted	Step 5		=(11)+(12)+(13)	0.29	1.53	0.31	0.31	0.00	0.13	0.13	0.00
15	Wrk RVU	Setup File	MFS		0.97	33.75	0.22	0.00	0.22	0.17	0.00	0.17
16	Dir_pct	Steps 6, 7	Surveys		25.6 %	18%	28.5%	28.5%	28.5%	28.9%	28.9%	28.9%
17	Ind_pct	Steps 6, 7	Surveys		74.4%	82%	71.5%	71.5%	71.5%	71.1%	71.1%	71.1%
18	Ind. Alloc. formula (1st part)	Step 8	See Step 8		((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)
19	Ind. Alloc. (1st part)	Step 8		See (18)	0.86	6.95	0.78	0.78	0.00	0.33	0.33	0.00

		Step	Source	Formula	99213 Office visit, est Non-facility	33533 CABG, arterial, single Facility	71020 Chest x-ray Non-facility	71020TC Chest x-ray Non-facility	7102026 Chest x-ray Non-facility	93000 ECG, complete Non-facility	93005 ECG, tracing Non-facility	93010 ECG, report Non-facility
20	Ind. Alloc. formulas (2nd part)	Step 8	See Step 8		(15)	(15)	(15)+(11)	(11)	(15)	(15)+(11)	(11)	(15)
21	Ind. Alloc. (2nd part)	Step 8		See (20)	0.97	33.75	0.32	0.10	0.22	0.28	0.11	0.17
22	Indirect Allocator (1st+2nd)	Step 8		=(19)+(21)	1.83	40.70	1.10	0.88	0.22	0.61	0.44	0.17
23	Indirect Adjustment (Ind Adj)	Steps 9-11	See footnote**		0.367	0.367	0.367	0.367	0.367	0.367	0.367	0.367
24	Adjusted Indirect Allocator	Steps 9-11	=Ind Alloc * Ind Adj		0.67	14.93	0.40	0.32	0.08	0.22	0.16	0.06
25	Ind.Practice Cost Index (PCI)	Steps 12-16	See Steps 12-16		1.094	0.892	0.859	0.859	0.859	0.928	0.928	0.928
26	Adjusted Indirect	Step 17	= Adj. Ind Alloc*PCI	=(24)*(25)	0.73	13.32	0.35	0.28	0.07	0.21	0.15	0.06
(27)	PE RVU	Steps 18-19	=(Adj Dir+Adj Ind) *budn	=((14)+(26)) *budn	1.03	14.85	0.66	0.59	0.07	0.34	0.28	0.06

Note: PE RVU in Table 1, row 27, may not match Addendum B due to rounding.

* The direct adj = [current pe rvus * CF * avg dir pct] / [sum direct inputs] = [Step 2] / [Step 3]

** The indirect adj = [current pe rvus * avg ind pct] / [sum of ind allocators] = [Step 9] / [Step 10]

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2. PE Revisions for CY 2010

a. SMS and Supplemental Survey Background

Currently, we use PE/HR obtained from the SMS surveys from 1995 through 1999. For several specialties that collected additional PE/HR data through a more recent supplemental survey, we accepted and incorporated these data in developing current PE/HR values.

While the SMS survey was not specifically designed for the purpose of establishing PE RVUs, we found these data to be the best available at the time. The SMS was a multi-specialty survey effort conducted using a consistent survey instrument and method across specialties. The survey sample was randomly drawn from the AMA Physician Masterfile to ensure national representativeness. The AMA discontinued the SMS survey in 1999.

As required by the BBRA, we also established a process by which specialty groups could submit supplemental PE data. In the May 3, 2000 interim final rule entitled, Medicare Program; Criteria for Submitting Supplemental Practice Expense Survey Data, (65 FR 25664), we established criteria for acceptance of supplemental data. The criteria were modified in the CY 2001 and CY 2003 PFS final rules with comment period (65 FR 65380 and 67 FR 79971, respectively). We currently use supplemental survey data for the following specialties: cardiology; dermatology; gastroenterology; radiology; cardiothoracic surgery; vascular surgery; physical and occupational therapy; independent laboratories; allergy/immunology; independent diagnostic testing facilities (IDTFs); radiation oncology; medical oncology; and urology.

Because the SMS data and the supplemental survey data are from different time periods, we have historically inflated them by the MEI to help put them on as comparable a time basis as we can when calculating the PE RVUs. This MEI proxy has been necessary in the past due to the lack of contemporaneous, consistently collected, and comprehensive multispecialty survey data.

b. Physician Practice Information Survey (PPIS)

The AMA has conducted a new survey, the PPIS, which was expanded (relative to the SMS) to include nonphysician practitioners (NPPs) paid under the PFS. The PPIS, administered in CY 2007 and CY 2008, was designed to update the specialty-specific PE/HR data used to develop PE RVUs.

The AMA and our contractor, The Lewin Group (Lewin), analyzed the PPIS data and calculated the PE/HR for physician and nonphysician specialties, respectively. The AMA's summary worksheets and Lewin's final report are available on the CMS Web site at *http://www.cms.gov/PhysicianFeeSched/.* (See AMA PPIS Worksheets 1–3 and Lewin Group Final Report PPIS.) We also included a table in the proposed rule showing the current indirect PE/HR based on SMS and supplemental surveys, the PPIS indirect PE/HR, and the indirect cost percentages of total costs (74 FR 33530 through 33531).

The PPIS is a multispecialty, nationally representative, PE survey of both physicians and NPPs using a consistent survey instrument and methods highly consistent with those used for the SMS and the supplemental surveys. The PPIS has gathered information from 3,656 respondents across 51 physician specialty and health care professional groups. We believe the PPIS is the most comprehensive source of PE survey information available to date.

As noted, the BBRA required us to establish criteria for accepting supplemental survey data. Since the supplemental surveys were specific to individual specialties and not part of a comprehensive multispecialty survey, we had required that certain precision levels be met in order to ensure that the supplemental data was sufficiently valid, and acceptable for use in the development of the PE RVUs. Because the PPIS is a contemporaneous, consistently collected, and comprehensive multispecialty survey, we do not believe similar precision requirements are necessary and we did not propose to establish them for the use of the PPIS data.

For physician specialties, the PPIS responses were adjusted for non-response bias. Non-response bias is the bias that results when the characteristics of survey respondents differ in meaningful ways, such as in the mix of practice sizes, from the general population. The non-response adjustment was developed based on a comparison of practice size and other characteristic information between the PPIS survey respondents and data from the AMA Masterfile (for physician specialties) or information from specialty societies (for non-physician specialties). For six specialties (chiropractors, clinical social workers, nuclear medicine, osteopathic manipulative therapy, physical therapy, and registered dietitians) such an adjustment was not possible due to a lack of available characteristic data. The AMA and Lewin have indicated that the non-response weighting has only a small impact on PE/HR values.

Under our current policy, various specialties without SMS or supplemental survey data have been crosswalked to other similar specialties to obtain a proxy PE/HR. For specialties that were part of the PPIS for which we currently use a crosswalked PE/HR, we proposed instead to use the PPIS-based PE/HR. We also proposed to continue current crosswalks for specialties that did not participate in PPIS.

Supplemental survey data on independent labs, from the College of American Pathologists, was implemented for payments in CY 2005. Supplemental survey data from the National Coalition of Quality Diagnostic Imaging Services (NCQDIS), representing IDTFs, was blended with supplementary survey data from the American College of Radiology (ACR) and implemented for payments in CY 2007. Neither IDTFs, nor Independent Labs, participated in the PPIS. Therefore, we proposed to continue using the current PE/HR that was developed using their supplemental survey data.

We did not propose to use the PPIS data for reproductive endocrinology, sleep medicine, and spine surgery since these specialties are not separately recognized by Medicare and we do not know how to blend this data with Medicare recognized specialty data. We sought comment on this issue.

We did not propose changes to the manner in which the PE/HR data are used in the current PE RVU methodology. We proposed to update the PE/HR data itself based on the new survey. We proposed to utilize the PE/HR developed using PPIS data for all Medicare recognized specialties that participated in the survey for payments effective January 1, 2010. The impact of using the new PPIS-based PE/HR is discussed in the Regulatory Impact Analysis in section XIII. of this final rule with comment period.

The following is a summary of the public comments received on the PPIS survey and our responses.

Comment: MedPAC was generally supportive of the use of the PPIS survey data, stating:

> Ensuring the accuracy of PE payments is important given that close to half of all payments under the physician fee schedule are associated with practice expense. The Commission has repeatedly raised concerns that the specialty-specific cost data that CMS uses to derive PE RVUs are not current for most specialties, which might lead to payments becoming inaccurate over time.

Compared with the multiple data sources that CMS currently relies on for practice cost information, the PPIS is a step forward because: (1) It reflects current practice patterns and costs; (2) it measures costs of nearly all physician and nonphysician specialties; and (3) it uses a standard protocol for all specialty groups that was designed to derive PE RVUs. However, CMS should provide more information about the PPIS's response rate and representativeness. We are also concerned that CMS has not laid out options for ensuring the accuracy of PE RVUs in the long term. As a future step, CMS should consider alternatives for collecting specialty-specific cost data or options to decrease the reliance on such data.

Response: We agree with MedPAC that the PPIS is a step forward compared to the data sources currently used in the development of the PE RVUs.

With respect to additional information on the PPIS survey, the AMA has continued to respond to requests from the individual specialty societies for additional data analysis as they have done since the PPIS results were first released. We have also performed further analyses in response to comments received on the proposed rule. The results of these analyses are available on our Web site (described later in this section) and have not changed our conclusion that the PPIS is the most comprehensive, multi-specialty, contemporaneous, consistently collected PE data source available.

We also agree with MedPAC that it is appropriate to consider the future of the PE RVUs moving forward. We did not propose any changes to the methodology in conjunction with the use of the PPIS data. However, we seek comments from other stakeholders on the issues raised by MedPAC for the future. In particular, we seek comments regarding MedPAC's suggestion that we consider alternatives for collecting specialty-specific cost data or options to decrease the reliance on such data. For example, MedPAC stated that ''CMS should consider if Medicare or provider groups should sponsor future data collection efforts, if participation should be voluntary (such as surveys) or mandatory (such as cost reports), and whether a nationally representative sample of practitioners would be sufficient for either a survey or cost reports.'' MedPAC also stated that one option for decreasing the reliance on specialty-specific cost data would be the elimination of specialty-specific cost pools from the method used to derive indirect PE RVUs. We would address any changes through future rulemaking.

Comment: In addition to MedPAC, numerous specialty groups and individual physicians and practitioners supported utilizing the PPIS data. The commenters included family practice, general practice, geriatrics, pediatrics, internal medicine, obstetrics and gynecology, general surgery, infectious disease, emergency medicine, psychiatry, anesthesiology, colorectal surgery, dermatology, endocrinology, gastroenterology, neurology, neurosurgery, ophthalmology, optometry, orthopedic surgery, osteopathic physicians, otolaryngology, pathology, physical medicine and rehabilitation, physical and occupational therapy, plastic surgery, podiatry, pulmonary disease, spine surgery, thoracic surgery, transplant surgery, and vascular surgery.

Those in favor of using the PPIS data made one or more of the following points:

- PPIS was a nationally representative survey providing the most up-to-date and comprehensive data available from 51 specialties. It was a highly scientific and controlled undertaking, using a survey instrument that the AMA took great care to design, test, and implement.
- Seventy organizations contributed to the costs of the survey and agreed to take responsibility for communicating and publicizing the effort in order to enhance response rates. All groups had ample time to review and provide input and received monthly updates on response rates for their group.
- PPIS followed the exacting criteria that CMS has established for gathering this type of data and for producing results that are acceptable for submission. The AMA worked with CMS's contractor to ensure that all data met these criteria and were analyzed consistently across the various physicians and practitioner specialties. Any data that did not meet the criteria such as response outliers were excluded.
- The vast majority of the data currently used are completely outdated. MedPAC and GAO have been calling on CMS to update PE payments. The annual update of such data is inadequate to capture the true changes in practice costs that physicians have experienced over the years.
- Supplemental survey data from a limited number of specialties have caused significant distortions and misallocations of PE payments, and provided an unfair advantage to some specialties. Many organizations were unable to submit supplemental survey data due to the high cost of gathering the data.
- Concurrently and uniformly collected data will correct payment imbalances caused by the supplemental surveys. Due to BN, this leads to a shift in payment to some specialties at the expense of others. The new data will reduce the payment gap between primary care and other specialties.
- Blending PPIS data with existing data would preserve distortions and continue utilization of data that are more than 10 years old for some groups.

Response: We appreciate the support of this broad-based and diverse mix of primary care, surgical, and other nonsurgical specialties for our proposal. We agree with the commenters that the PPIS is the most comprehensive, multi-specialty, contemporaneous, consistently collected PE data source available.

Comment: There were also many specialty groups and individual physicians and practitioners strongly opposed to the use of the PPIS data. The commenters included representatives of the specialties of cardiology, radiation oncology, medical oncology, interventional radiology, hematology, nuclear medicine, urology, rheumatology, and dieticians. Those opposed to using the PPIS data made one or more of the following points:

- Some commenters stated that data were not collected in a contemporaneous, consistent, and comprehensive way;
- Some commenters stated that the PPIS should be subject to the same level of analysis as the supplemental surveys to assess accuracy and precision. The commenters also indicated that the survey did not meet the target goal for useable responses. The commenters stated that the low response rates, for some specialties, means that the data are not representative of the specialties' PEs. The commenters also stated that specialty societies should be given the names of the survey respondents, especially those that failed to fully complete the survey, so they could be contacted;
- Some commenters stated that there was not adequate transparency in the PPIS survey process and that there was insufficient information provided about the survey methodology and process;
- Some commenters stated that CMS should withdraw the proposal and take the time necessary to adequately examine the data submitted by AMA, consider changes to the PE methodology, and solicit public input on the validity of the data and the most appropriate way to integrate this data into the PFS; and
- Some commenters stated that if PPIS data is used, it should be blended with supplemental survey data and/or phased in over a number of years.

Response: The PPIS uses a consistent survey instrument and methodology across all specialty and health care professional groups. The sample was drawn from the AMA's Physician Masterfile, which is a listing of all member and non-member physicians in the United States. The survey was conducted in conjunction with national medical specialty societies and other health care professionals, representing 51 specialties and health professions in order to maximize the overall response rate. Respondents could submit information through multiple modalities, including telephone, fax, and Web-based reporting.

The survey was conducted by external contractors. In 2007 the PPIS project was contracted to the Gallup Organization. In late 2007 the AMA transitioned the survey effort to dmrkynetec, formally Doane Marketing Research, to complete the project. Dmrkynetec conducted the majority of the specialty level surveys that were previously implemented by CMS. Dmrkynetec used the same survey instruments as did the Gallup Organization in order that survey data collected by Gallup could be appropriately merged in the dmrkynetec data collection.

The survey methodology was highly consistent with the prior SMS methodology because only small deviations were allowed to accommodate practice style differences across the various groups surveyed. The PPIS was conducted in accordance with known conventions governing PE collection activities. One hundred completed surveys for each specialty was set as a goal for the PPIS, but was not a minimum requirement. More than 7,000 surveys were collected for 51 physicians, non MD/DO specialties, and health professions. For the majority of specialties, at least 100 surveys were collected.

The AMA provided specialty groups with information on the survey throughout the survey process. Monthly progress reports were issued on response rates. Due to confidentiality agreements with the AMA and participating specialty groups, raw survey data was not distributed to CMS or the specialty groups. However, this does not mean that analysis was not performed on the PPIS data.

In conjunction with publication of the proposed rule, we posted information on our Web site on physician response rates, precision and PE/HR. In addition, we posted Lewin's report entitled, ''Physician Practice Information Survey (PPIS) Data Submitted for 2010: Non-MD/DO and Health Professionals Practice Information'' (June 19, 2009). This report includes information on the PPIS survey process as well as the methodology for determining the PE/HR.

As noted earlier in our response to the MedPAC comment, the AMA has continued to respond to requests from the individual specialty societies for additional data analysis, as they have done since the PPIS results were first released. In response to comments received on the proposed rule, we have also performed additional analyses of summary data supplied by the AMA, the supplemental survey, and cardiology, urology, and radiology groups. This additional analysis indicates that while the PE/HR for these specialties differs between the data sources reviewed for certain practice sizes, these differences do not validate the commenters' conclusion that the PPIS data is invalid. We continue to believe that the PPIS is the most appropriate data source available for the development of resource-based PE RVUs. To view this analysis, please see our Web site at *http://www.cms.hhs.gov/PhysicianFeeSched/*. (At this Web site, Go to ''PFS Federal Regulation Notices'' tab, and then chose ''CMS–1413–P.'' Lewin's original report is listed under the CY 2010 PFS proposed rule page. The additional AMA information and analysis of the PPIS is available at *http://www.ama-assn.org/go/ppisurvey*.

We disagree with some commenters that the same precision requirements that applied to the individual specialty supplemental surveys should apply to the broad multispecialty contemporaneous PPIS. Each individual specialty supplemental survey was being used alongside the multispecialty contemporaneous SMS survey data for all the other specialties. This is not the case for the PPIS data. We proposed to use the PPIS data in its entirety for all Medicare recognized specialties, with the exception of two supplier specialties that did not participate in the PPIS. Precision requirements were appropriate, and required by the BBRA, in the context of the selective acceptance of individual supplemental surveys, but are not necessary in the context of the much broader adoption of the PPIS data.

We also disagree that we should blend the supplemental survey data with the PPIS data. One of the advantages of the PPIS data is precisely that it is contemporaneous and collected in a consistent, broad multi-specialty manner. Blending this data with the supplemental survey data weakens the advantage of using the PPIS data, as was pointed out by commenters who favored its use.

However, we do recognize that some specialties experience significant payment reductions with the use of the PPIS data. Given the magnitude of these payment reductions for some specialties, we agree with commenters who suggested a transition to the new PE RVUs developed using the PPIS data. Historically, we have provided for 4-year transitions when we have significantly altered the PE methodology. While we did not propose any changes to the methodology in the proposed rule, we are persuaded by commenters that the use of the new PPIS data has a sufficiently significant impact to warrant the use of such a transition. In light of the comments received and our past practice, we are finalizing a 4-year transition (75/25, 50/50, 25/75, 0/100) from the current PE RVUs to the PE RVUs developed using the new PPIS data.

Comment: Some commenters that supported the use of the PPIS data and some who opposed its use claimed that Medicare pays only 51 percent of direct costs. Commenters maintained that the PE methodology results in the underpayment of procedures with high direct costs, and will shift procedures from the office to the higher cost hospital setting.

Response: The purpose of the resource-based PE methodology is to develop RVUs within the overall PFS BN requirements. We are unaware of any independent analysis that indicates that Medicare pays 51 percent of direct costs as a result of these BN requirements. In the PE methodology, there is a scaling factor applied in the development of the direct PE portion of the PE RVUs and there is a scaling factor applied in the development of the indirect PE portion. We believe that commenters may be misinterpreting the scaling factor applied in the development of the direct cost portion of the PE RVUs.

The PPIS data indicated a significant decrease in the percentage of PEs that are attributable to direct PEs and a corresponding increase in the percentage that are attributable to indirect PEs. The incorporation of the PPIS data, therefore, results in a decrease in the scaling factor applied in the development of the direct cost portion of the PE methodology from its current value of 0.63 to its new value of 0.51 and a corresponding increase in the scaling factor applied in development of the indirect cost portion. As stated earlier, the PPIS is the most comprehensive, multi-specialty, contemporaneous, consistently

collected source of PE data. The PPIS data indicates that direct costs are a smaller proportion of total PE costs for almost every single specialty surveyed (see Table 2). We are incorporating this result into our methodology and disagree with commenters that this empirically based decrease in the scaling factor for the direct cost portion of the PE RVU using the PPIS survey data is inappropriate.

Comment: The American Society of Clinical Oncology (ASCO) noted that section 303 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173) (MMA) added section 1848(c)(2)(H) of the Act, which requires us to use their supplemental survey submitted in 2003 for oncology drug administration services.

Response: We have reviewed the MMA provision and agree that, as amended, section 1848(c)(2)(H)(i) of the Act requires that we continue to use the supplemental survey data for oncology. We have revised the PE/HR for medical oncology, hematology, and hematology/oncology to reflect the continued use of these supplemental survey data.

Comment: Several commenters indicated that PPIS data for reproductive endocrinology, sleep medicine, and spine surgery should not be used because they are not separately recognized specialties by Medicare and it is difficult to blend this data with data from specialties that are recognized. Other commenters disagreed and recommended weights we could use to blend the PPIS data with the data from the recognized specialties for certain services.

Some commenters encouraged us to make these Medicare-recognized specialties because they perform work that is separate and apart from their parent specialty, require additional training, and have separate liability issues. Other commenters opposed the recognition of separate specialties for these groups, indicating that they are not markedly different from their parent specialties.

Response: We did not specifically solicit comments on whether reproductive endocrinology, sleep medicine, and spine surgery should be separately recognized Medicare specialties, nor did we make such a proposal. Specialties seeking such recognition must make a formal request using our existing process. (See the CMS Internet-Only Medicare Claims Processing Manual, Pub. L. 100–04, Chapter 26, Section 10.8, Requirements for Specialty Codes.)

We did consider the comments on blending in the PPIS data for the above physician groups as suggested by some commenters. However, we are more persuaded by the commenters who indicated that determining the correct blend would be difficult. We are reluctant to assign utilization weights to the mix of specialties that perform these services in the absence of actual claims data. We suggest that the commenters who wish us to use the PPIS data for these groups apply for a specialty code using our normal process. If approved, the claims data associated with the new specialty code could be used to incorporate the PPIS survey data for that specialty.

Comment: A group of commenters indicated that they were precluded from participating in the PPIS. Some commenters representing portable x-ray suppliers indicated that an inability to participate in the PPIS resulted in an inappropriately low crosswalk for their specialty to radiology.

Response: We did not exclude any specialty from participating in PPIS. Individual specialties made the decision whether to participate. However, we agree with the commenters representing portable x-ray suppliers that radiology may not be the most appropriate crosswalk for their specialty given the relatively low amount of physician time in the services performed by the specialty. In light of these comments, we are changing the PE/HR crosswalk for portable x-ray suppliers to IDTF, a specialty similar with respect to the physician time issue.

Comment: As noted earlier, commenters representing freestanding radiation oncology centers are opposed to the use of the PPIS data. However, if CMS were to use the PPIS data, these commenters requested that CMS adjust the PE/HR used for freestanding radiation oncology centers by eliminating the weighting of the data and by eliminating 21 survey responses whose physician hour information was missing from the data and imputed. The commenters also requested that we update the weights used to blend the hospital-based and freestanding radiation oncology center survey data based on more recent claims data.

Response: We agree with the commenters that it would be more consistent with the methodology used for other specialties to remove the 21 survey responses whose physician hour information was missing from the data and imputed. We also agree it is more appropriate to update the weights used to blend the hospital-based and freestanding radiation oncology center survey data based on more recent claims data. However, we disagree that it is appropriate to eliminate the weighting of the survey data, especially with the 21 observations with imputed physician practice hours removed from the survey sample respondent mix. Consistent with the weighting methodology for other physician specialties, we applied the AMA Masterfile weights to the data. More details on our analysis of this comment can be found on our Web site.

Comment: Some commenters indicated that since, by statute, registered dieticians are paid 85 percent of what a physician would be paid for providing medical nutrition therapy services, the PPIS survey data for registered dieticians should not be used in calculation of PE RVUs; and that we should, therefore, base the RVUs for these services only on the physician specialties that provide the service.

Response: We agree with commenters that, under the current PE methodology, the PPIS survey data for registered dieticians should not be used in the calculation of PE RVUs since they are paid 85 percent of what a physician would be paid for providing the service. To include them in the PE calculation would influence the rate setting to include what the services would be paid if performed by registered dieticians and not strictly on what the payment rate would be if provided by physicians. We will crosswalk the specialty of registered dietician to the ''all physician'' PE/HR rate.

In summary, based on the decisions described above, Table 2 shows the indirect PE/HR for the specialties that have PPIS survey data that we are adopting to calculate the PE RVUs. Also shown for these specialties is the previous indirect PE/HR used to calculate the PE RVUs. Note that for oncology, clinical laboratories, and IDTFs we are continuing to use the supplemental survey data as described above. Consistent with our past practice, the previous indirect PE/HRs for these specialties have been updated to CY 2006 using the MEI to put them on a comparable basis with the PPIS survey data.

TABLE 2—INDIRECT PE/HR FOR THE SPECIALTIES THAT HAVE PPIS SURVEY DATA

Specialty	Previous indirect PE/HR	Final rule indirect PE/HR	Previous indirect %	Final rule indirect %
All Physicians	$59.04	86.36	67	74
Allergy and Immunology	153.29	162.68	62	67
Anesthesiology	19.76	29.36	56	82
Audiology	59.04	72.17	67	85
Cardiology	131.02	88.04	56	65
Cardiothoracic Surgery	61.75	67.83	68	83
Chiropractor	49.60	65.33	69	86
Clinical Laboratory (Billing Independently)	66.46	68.32	37	37
Clinical Psychology	29.07	20.07	90	93
Clinical Social Work	29.07	17.80	90	97
Colon & Rectal Surgery	53.93	90.84	77	80
Dermatology	158.49	184.62	70	70
Emergency Medicine	36.85	38.36	88	94
Endocrinology	49.60	84.39	69	73
Family Medicine	52.79	90.15	62	76
Gastroenterology	101.30	96.78	70	75
General Practice	52.79	78.59	62	69
General Surgery	53.93	82.73	77	82
Geriatrics	49.60	54.14	69	74
Hand Surgery	98.56	148.78	72	77
Independent Diagnostic Testing Facilities	466.16	501.45	50	51
Internal Medicine	49.60	84.02	69	76
Interventional Pain Medicine	59.04	156.79	67	70
Interventional Radiology	118.48	82.56	58	81
Medical Oncology	141.84	145.81	59	59
Nephrology	49.60	66.00	69	80
Neurology	66.05	110.39	74	87
Neurosurgery	89.64	115.76	86	87
Nuclear Medicine	118.48	39.80	58	77
Obstetrics/Gynecology	69.74	99.32	67	67
Ophthalmology	103.28	170.07	65	70
Optometry	59.04	88.02	67	77
Oral Surgery (Dentist only)	96.01	173.19	71	65
Orthopaedic Surgery	98.56	131.40	72	81
Osteopathic Manipulative Therapy	59.04	53.93	67	93
Otolaryngology	96.01	141.54	71	75
Pain Medicine	59.04	122.42	67	70
Pathology	59.80	74.98	70	74
Pediatrics	51.52	76.27	62	69
Physical Medicine and Rehabilitation	84.92	110.13	71	84
Physical Therapy	35.17	57.26	65	84
Plastic Surgery	99.32	134.81	67	74
Podiatry	59.04	74.76	67	82
Psychiatry	29.07	30.10	90	94
Pulmonary Disease	44.63	55.26	76	74
Radiation Oncology (Hospital Based & Freestanding)	114.00	165.10	50	57
Radiology	118.48	95.60	58	71
Rheumatology	84.92	98.08	71	67
Urology	119.57	97.01	69	73
Vascular Surgery	60.10	83.98	63	73

c. Equipment Utilization Rate

As part of the PE methodology associated with the allocation of equipment costs for calculating PE RVUs, we currently perform these calculations with an equipment usage assumption of 50 percent. In the CY 2008 PFS proposed rule (72 FR 38132), we noted that if the assumed equipment usage percentage is set too high, the result would be an insufficient allowance at the service level for the practice costs associated with equipment. If the assumed equipment usage percentage is set too low, the result would be an excessive allowance for the practice costs of equipment at the service level. We acknowledged that the current 50 percent usage assumption does not capture the actual usage rates for all equipment, but stated that we did not believe that we had strong empirical evidence to justify any alternative approaches.

In the CY 2008 PFS final rule with comment period, we summarized comments received on this issue. Commenters' recommendations about making adjustments to the 50 percent utilization rate assumption varied. Some commenters recommended that we do nothing until stronger empirical evidence is available. Other commenters recommended a decrease in the utilization assumption while others recommended an increase in the utilization assumption. We agreed with the commenters that the equipment utilization rate should continue to be examined for accuracy. We indicated that we would continue to monitor the appropriateness of the equipment utilization assumption, and evaluate whether changes should be proposed in light of the data available.

In the CY 2010 PFS proposed rule (74 FR 33532), we acknowledged that since the publication of the CY 2008 PFS final rule with comment period, MedPAC addressed this issue in its March 2009 Report to Congress (see *http://www.medpac.gov/documents/Mar09_EntireReport.pdf).* In part of its discussion, MedPAC stated:

> In 2006, the Commission sponsored a survey by NORC of imaging providers in six markets, which found that MRI and CT machines are used much more than the 25 hours per week that CMS assumes (Table 2B–6). According to data from this survey, MRI scanners are used 52 hours per week, on average (median of 46 hours), and CT machines are operated 42 hours per week, on average (median of 40 hours) (NORC 2006). Although the survey results are not nationally representative, they are representative of imaging providers in the six markets included in the survey. We also analyzed data from a 2007 survey of CT providers by IMV, a market research firm (IMV Medical Information Division 2008). IMV data are widely used in the industry and have also appeared in published studies (Baker et al. 2008, Baker and Atlas 2004). Using IMV's data on 803 nonhospital CT providers (imaging centers, clinics, and physician offices), we calculated that the average provider uses its CT scanner 50 hours per week, which is twice the number CMS assumes. The IMV survey also found that nonhospital providers increased the average number of procedures per CT machine by 31 percent from 2003 to 2007, which indicates that providers either used their machines more hours per day or performed more scans per hour (IMV Medical Information Division 2008) (p. 108).

In the proposed rule, we stated that the studies cited by MedPAC indicated that the current equipment usage rate assumption is significantly understated, especially with respect to the types of high cost equipment that were the subject of the studies. The current 50 percent utilization rate translates into about 25 hours per week out of a 50-hour work week. The median value of 46 hours for Magnetic Resonance Imaging equipment from the first study cited by MedPAC is equivalent to a utilization rate of 92 percent on a 50-hour week. For Computed Tomography scanners, averaging the value from the first study of 40 hours per week and the value from the second study of 50 hours per week yields 45 hours and is equivalent to a 90 percent utilization rate on a 50-hour work week. Therefore, in the CY 2010 PFS proposed rule, we proposed to increase the equipment usage rate to 90 percent for all services containing equipment that cost in excess of $1 million dollars. We stated that the studies cited by MedPAC suggested that physicians and suppliers would not typically make huge capital investments in equipment that would only be utilized 50 percent of the time. We stated that we would continue to explore data sources regarding the utilization rates of equipment priced at less than $1 million dollars, but we did not propose a change in the usage rate for this less expensive equipment.

The following is a summary of the public comments received and our responses.

Comment: We received comments supporting our proposal to apply a 90 percent equipment utilization rate to expensive equipment priced at more than $1 million and comments opposing our proposal. MedPAC stated:

> ''The Commission supports CMS's proposal as it applies to diagnostic imaging machines that cost more than $1 million, and we encourage CMS to explore increasing the equipment use factor for diagnostic imaging machines that cost less than $1 million. MedPAC did not contemplate applying the policy to radiation therapy machines.''

Commenters supporting our proposal cited the MedPAC studies and the rationale we provided in the proposed rule.

Commenters opposing our proposal stated that the Balanced Budget Act of 1997 (BBA) directed CMS to ''utilize, to the maximum extent practicable, generally accepted cost accounting principles which: (1) Recognize all staff, equipment, supplies and expense, not just those which can be tied to specific procedures; and (2) use actual data on equipment utilization and other key assumptions.'' The commenters stated that the equipment usage proposal violates this provision of the BBA since we lacked sufficient empirical justification for the change. The commenters indicated that the National Opinion Research Center survey data, which was one data source used by MedPAC, was not nationally representative, and was never intended to determine equipment usage rates.

Some commenters referenced information submitted by the Radiology Benefit Management Association (RBMA) based on a survey of its members. The commenters stated that the information supported maintaining a 50 percent utilization usage rate assumption for diagnostic imaging equipment. The commenters also stated that the information indicated differences in utilization rates between rural and urban areas and that our proposal would create access issues, especially in rural areas.

In MedPAC's comment letter, it agreed with CMS that ''decreasing PE RVUs for expensive diagnostic imaging services should not affect access to care in rural areas.''

The AMA submitted summary equipment utilization data from the PPIS survey on MRI, CT, angiography, IMRT, and gamma camera. It stated that although there was a relatively small sample size, the survey responses suggest that equipment utilization varies depending on the type of equipment involved. The AMA requested that we allow specialty societies to provide data supporting lower utilization rates, if appropriate. It stated that this would allow for varying equipment utilization rate assumptions depending on the type of equipment being used, rather than a single utilization assumption.

Some commenters indicated that even if the available data did indicate a higher utilization rate for certain types of diagnostic equipment, we should not apply the change to all types of expensive diagnostic equipment. For example, we should not apply the usage rate to new imaging technology.

Some commenters requested that we not change the equipment usage rate assumption to 90 percent for any equipment until additional data sources can be identified. The commenters suggested that the equipment usage rate policy should not be limited to increasing usage rate assumptions but should also include potentially decreasing equipment usage rate assumptions when appropriate.

If we were to implement a higher utilization rate, some commenters suggested that the change be phased in over a number of years.

Response: We appreciate all of the comments received on this issue. At the time that we published the proposed rule, we had the data on MRI and CT from the MedPAC analysis. We indicated that the MedPAC studies suggested that physicians and suppliers would not typically make significant capital investments in equipment that would only be utilized 50 percent of the time. Commenters opposed to our proposal have questioned both the validity of the MedPAC analysis for CT and MRI and extrapolation of this data to all expensive equipment, particularly therapeutic equipment. While we are persuaded by PPIS data on angiography, IMRT, and Gamma Camera that the extrapolation of the MRI and CT data to all expensive equipment may be inappropriate, we disagree with commenters who indicated that we do not have an empirical basis for applying a 90 percent usage rate to MRIs and CTs.

As described earlier, the MedPAC analysis was performed on two data sources for different types of equipment. The first data source was the survey done by NORC for MRIs and CTs. The second data source was the IMV data for

CT scans. With respect to MRIs and CTs, we have now also received summary information from the RBMA and summary PPIS survey data from the AMA. The PPIS survey data results for MRIs (n=97) and CTs (n=86) are consistent with the findings from the MedPAC studies on MRIs and CTs. However, the data from the RBMA (17 members submitted a total of 46 center surveys) indicates a lower utilization rate for CT and MRI.

As we have described in section II.A.2.b. of this final rule with comment, the PPIS is the best available data source currently available on PEs. Given the corroboration of the MedPAC analysis by the PPIS data, we are confident that we are using the best data currently available on the utilization of MRIs and CTs (90 percent), consistent with the BBA requirement that we use actual data on equipment utilization.

We are open to receiving more comprehensive data than the responses of 16 RBMA members on this issue from the RBMA or other members of the public. We will evaluate any data submitted for consideration in future rulemaking.

We continue to agree with the MedPAC analysis and comment indicating that decreasing the PE payments for expensive diagnostic imaging services should not affect access to care in rural areas.

We also agree with commenters that it would be appropriate to transition the new PE RVUs developed using the higher 90 percent utilization rate for MRIs and CTs. As discussed elsewhere in this final rule, we are providing for a 4-year transition (25/75, 50/50, 75/25, 100/0) to the new PE RVUs.

As indicated above, we are not finalizing our proposal to increase the utilization rate assumption for expensive equipment other than MRIs and CTs, including therapeutic equipment. We are finalizing our proposal to increase the utilization rate to 90 percent for expensive diagnostic equipment priced at more than $1 million.

d. Miscellaneous PE Issues

As we have discussed in the past rulemaking (see the CY 2007 and CY 2008 PFS final rules with comment period (71 FR 69647 and 72 FR 66236, respectively), we continue to have concerns about the issue of PE RVUs for services which are utilized 24 hours a day/7 days a week, such as certain monitoring systems. For example, the PE equipment methodology was not developed with this type of 24/7 equipment in mind. As stated in the CY 2010 PFS proposed rule (74 FR 33532), we are continuing to analyze the issue of PEs for services, which are utilized 24 hours a day/7 days a week to identify any modifications to our methodology that would address the specific ''constant use'' issues associated with these services. Services that are currently contractor priced in CY 2009 would remain contractor priced in CY 2010. We also indicated that any proposed changes will be communicated through future rulemaking.

Comments: We received three comments regarding the proposal to continue to contractor price these services. All three commenters supported the establishment of a national price for cardiac outpatient telemetry. The commenters also indicated that they believe they were the only ones that should be billing these codes.

Response: We will finalize our proposal to continue to contractor price these services in 2010 so that we may conduct further analysis. Any proposed changes will be communicated through future rulemaking.

As discussed in the proposed rule, (74 FR 33532) we received comments regarding the PE direct cost inputs (for example, supply costs and the useful life of the renewable sources) related to the high dose radiation therapy (HDRT) and placement CPT codes (CPT codes 77785, *Remote afterloading high dose rate radionuclide brachytherapy; 1 channel,* 77786, *Remote afterloading high dose rate radionuclide brachytherapy; 2–12 channels,* 77787, *Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels).* Based on our review of these codes and comments received, we requested that the AMA RUC consider these CPT codes for additional review.

Comment: The AMA RUC reviewed these CPT codes based on our request and recommended revisions to the clinical labor staff type, supplies, and equipment. The AMA RUC also recommended further discussion between the specialty and CMS regarding a resolution regarding the useful life of Iridium-192 source. The AMA RUC and other commenters stated that the useful life of the Iridium-192 source is 70 to 90 days. However, many commenters stated that physician offices enter into 1 year contracts for its replacement.

Several commenters supported the AMA RUC's recommended changes to the practice expense inputs for these codes. The commenters agreed that certain direct PE inputs were previously omitted.

Response: We accept the AMA RUC's recommendations regarding the direct PE inputs for these CPT codes. Based on the comments received and further analysis, we are changing the useful life of the Iridium-192 source from 5 years to 1 year and it will be considered as equipment. We are also revising the direct PE inputs for clinical labor staff type, supplies, and equipment.

e. AMA RUC Recommendations for Direct PE Inputs

The AMA RUC provided recommendations for PE inputs for the codes listed in Table 3 (74 FR 33532).

TABLE 3—CODES WITH AMA RUC PE RECOMMENDATIONS

CPT [1] code	Description
37183	Remove hepatic shunt (tips).
47382	Percut ablate liver rf.
50200	Biopsy of kidney.
55873	Cryoablate prostate.
93025	Microvolt t-wave assess.

[1] CPT codes and descriptions are Copyright 2009 American Medical Association.

In the proposed rule, we stated that we were in agreement with the AMA RUC recommendations for the direct PE inputs for the codes listed in Table 3 and proposed to adopt these for CY 2010.

Comment: Several commenters stated that it did not appear that we had adopted the AMA RUC recommendations for these codes. Commenters requested that we review their direct PE inputs to determine if we had adopted the RUC's recommendations.

Response: We have reviewed the direct PE inputs for these codes and it appears that some were omitted in error. We have now updated the PE inputs for these codes consistent with the RUC recommendation.

f. Practice Expense for Intranasal Vaccine Administration Codes (CPT Codes 90467, 90468, 90473, and 90474)

Comment: We received a comment from a manufacturer that the payment for the intranasal vaccine administration codes (represented by CPT codes 90467, 90468, 90473, and 90474) is approximately half the rate of the injected vaccine administration codes (represented by CPT codes 90465, 90466, 90471, and 90472). The commenter stated that the apparent source of the difference is the clinical staff time inputs of the PE component of the RVUs for these codes. The commenter noted that these codes are used to administer the intranasal form

of the influenza vaccine to healthy individuals between 2 to 49 years of age.

Response: We responded to a similar comment in the CY 2008 PFS final rule with comment period (72 FR 66242). At that time, we stated that a manufacturer had expressed concern that the PE RVUs for intranasal administration of vaccines (CPT codes 90467/8 and 90473/4) are inappropriately low and should be equalized to the injectable immunization administration PE RVUs. The commenter stated that when the codes were re-evaluated in 2004 there was not enough experience in the office to fully understand the time associated with providing an intranasal vaccine. The commenter stated that specialty organizations have indicated that this issue is worth reexamining and indicated that they had been encouraged to communicate with the AMA RUC in support of equalizing payment for the codes. In our response we stated that we appreciated the commenter's concerns about the disparity in the PE RVUs for the intranasal and injectable immunization administration procedures. To the extent that these concerns related to the direct PE inputs, we encouraged the commenters to work with the specialty organizations to determine if it was appropriate to bring these codes forward for further AMA RUC review.

The AMA RUC reviewed the immunization administration services (CPT codes 90465 through 90474) in February 2008. It recommended similar PE inputs for the intramuscular and intranasal immunization administration codes. In the CY 2009 PFS final rule with comment period (73 FR 38512), we stated that we accepted all of the AMA RUC recommendations, except for inclusion of the clinical staff time related to quality activities for the codes. In the CY 2009 PFS final rule with comment period (73 FR 69736), we stated that we had reexamined the issue and that there was evidence to support the inclusion of QA time in this case. We revised the PE database to reflect QA time for these codes.

B. Geographic Practice Cost Indices (GPCIs): Locality Discussion

1. Update—Expiration of 1.0 Work GPCI Floor

Section 1848(e)(1)(A) of the Act requires us to develop separate Geographic Practice Cost Indices (GPCIs) to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (that is, work, PE and malpractice). While requiring that the PE and malpractice GPCIs reflect the full relative cost differences, section 1848(e)(1)(A)(iii) of the Act requires that the physician work GPCIs reflect only one-quarter of the relative cost differences compared to the national average.

Section 1848(e)(1)(C) of the Act requires us to review and, if necessary, adjust the GPCIs at least every 3 years. This section also specifies that if more than 1 year has elapsed since the last GPCI revision, we must phase in the adjustment over 2 years, applying only one-half of any adjustment in each year. As discussed in the CY 2009 PFS final rule with comment period (73 FR 69740), the CY 2009 adjustment to the GPCIs reflected the fully implemented fifth comprehensive GPCI update. We noted that a 1.0 work GPCI floor was enacted and implemented for CY 2006, and was set to expire on June 30, 2008. We also noted that section 134 of the MIPPA extended the 1.0 work GPCI floor from July 1, 2008, through December 31, 2009. Additionally, section 1848(e)(1)(G) of the Act, as amended by section 134(b) of the MIPPA, set a permanent 1.5 work GPCI floor in Alaska for services furnished beginning January 1, 2009. Therefore, as required by the MIPPA, beginning on January 1, 2010, the 1.0 work GPCI floor will be removed. However, the 1.5 work GPCI floor for Alaska will remain in place. See Addenda D and E of this final rule for the GPCIs and summarized geographic adjustment factors (GAFs), respectively.

Comment: A few commenters urged us to make the 1.0 work GPCI floor permanent.

Response: With regard to the 1.0 work GPCI floor, we do not have the authority to extend this provision beyond December 31, 2009. As explained in the CY 2010 PFS proposed rule (74 FR 33533), section 134 of the MIPPA only extended the 1.0 work GPCI floor from July 1, 2008, through December 31, 2009.

2. Payment Localities

a. Background

As stated above in this section, section 1848(e)(1)(A) of the Act requires us to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (this is, work, PE, and malpractice). Payments under the PFS are based on the relative resources involved in furnishing physicians' services, and are adjusted for differences in relative resource costs among payment localities using the GPCIs. As a result, PFS payments vary between localities.

The current PFS locality structure was developed and implemented in 1997. There are currently 89 localities including 37 higher-cost areas; 16 Rest of State areas (comprising the remaining counties not located in a higher-cost area within a State); 34 Statewide areas; and Puerto Rico and the Virgin Islands which are designated as ''territory-wide'' localities. The development of the current locality structure is described in detail in the CY 1997 PFS proposed rule (61 FR 34615) and the subsequent final rule (61 FR 59494).

As we have frequently noted, any changes to the locality configuration must be made in a budget neutral manner within a State and can lead to significant redistributions in payments. For many years, we have not considered making changes to localities without the support of a State medical association in order to demonstrate consensus for the change among the professionals whose payments would be affected (with some increasing and some decreasing). However, we have recognized that, over time, changes in demographics or local economic conditions may lead us to conduct a more comprehensive examination of existing payment localities.

Payment Locality Approaches Discussed in the CY 2008 PFS Proposed Rule

For the past several years, we have been involved in discussions with California physicians and their representatives about recent shifts in relative demographics and economic conditions among a number of counties within the current California payment locality structure. In the CY 2008 PFS proposed and final rules with comment period, we described three potential options for changing the payment localities in California (72 FR 38139 and 72 FR 66245, respectively).

After reviewing the comments on these options, we decided not to proceed with implementing any of them at that time. We explained that there was no consensus among the California medical community as to which, if any, of the options would be most acceptable. We also received suggestions from the Medicare Payment Advisory Commission (MedPAC) for developing changes in payment localities for the entire country and other States expressed interest in having their payment localities reconfigured as well. In addition, other commenters wanted us to consider a national reconfiguration of localities rather than just making changes one State at a time. Because of the divergent views

expressed in comments, we explained in the CY 2008 PFS final rule with comment period that we intended to conduct a thorough analysis of potential approaches to reconfiguring localities and would address this issue again in future rulemaking.

Interim Study of Alternative Payment Localities Under the PFS

As a follow-up to the CY 2008 PFS final rule with comment period, we contracted with Acumen, LLC (Acumen), to conduct a preliminary study of several options for revising the payment localities on a nationwide basis. The contractor's interim report was posted on the CMS Web site on August 21, 2008, and we requested comments from the public. The report entitled, ''Review of Alternative GPCI Payment Locality Structures,'' is still accessible from the CMS PFS Web page under the heading ''Interim Study of Alternative Payment Localities under the PFS.'' The report may also be accessed directly from the following link: *http://www.cms.hhs.gov/PhysicianFeeSched/10_Interim_Study.asp#TopOfPage.* We accepted comments on the interim report through November 3, 2008. The alternative locality configurations discussed in the report are described briefly below in this section.

Option 1: CMS Core Based Statistical Area (CBSA) Payment Locality Configuration

This option uses the Office of Management and Budget (OMB's) Metropolitan Statistical Area (MSA) designations for the payment locality configuration. MSAs would be considered as urban CBSAs. Micropolitan Areas (as defined by OMB) and rural areas would be considered as non-urban (rest of State) CBSAs. This approach would be consistent with the inpatient hospital prospective payment system (IPPS) pre-reclassification CBSA assignments and with the geographic payment adjustments used in other Medicare payment systems. This option would increase the number of localities from 89 to 439.

Option 2: Separate High Cost Counties From Existing Localities (Separate Counties)

Under this approach, higher cost counties are removed from their existing locality structure and they would each be placed into their own locality. This option would increase the number of localities from 89 to 214 using a 5 percent GAF differential to separate high cost counties.

Option 3: Separate MSAs From Statewide Localities (Separate MSAs)

This option begins with Statewide localities and creates separate localities for higher cost MSAs (rather than removing higher cost counties from their existing locality as described in option 2). This option would increase the number of localities from 89 to 130 using a 5 percent GAF differential to separate high cost MSAs.

Option 4: Group Counties Within a State Into Locality Tiers Based on Costs (Statewide Tiers)

This option creates tiers of counties (within each State) that may or may not be contiguous but share similar practice costs. This option would increase the number of localities from 89 to 140 using a 5 percent GAF differential to group similar counties into Statewide tiers.

Additionally, as discussed in the interim locality study report, our contractor, Acumen, applied a ''smoothing'' adjustment to the current PFS locality structure, as well as to each of the alternative locality configurations (except option 4: Statewide Tiers). The ''smoothing'' adjustment was applied to mitigate large payment differences (or payment ''cliffs'') between adjacent counties. Since large payment differences between adjacent counties could influence a physician's decision on a practice location (and possibly impact access to care), the ''smoothing'' adjustment was applied to ensure that GAF differences between adjacent counties do not exceed 10 percent. (For more information on the ''smoothing'' adjustment see the interim locality study report on the PFS Web page via the link provided above).

b. Summary of Public Comments on Interim Locality Study Report

In the CY 2009 PFS proposed rule (73 FR 38514), we encouraged interested parties to submit comments on the options presented both in the proposed rule and in the interim report posted on our Web site. We also requested comments and suggestions on other potential alternative locality configurations (in addition to the options described in the report). Additionally, we requested comments on the administrative and operational issues associated with the various options under consideration. We also emphasized that we would not be proposing any changes to the current PFS locality structure for CY 2009 and that we would provide extensive opportunities for public comment before proposing any change.

In the CY 2010 PFS proposed rule (74 FR 33533), we noted that approximately 200 industry comments were submitted on the alternative locality options discussed in the CY 2009 PFS proposed rule and on the interim locality study report. Comments were submitted from various specialty groups, medical societies, state medical associations, individual practitioners, and beneficiaries. Commenters generally commended us for acknowledging the need to reconfigure PFS payment localities and expressed support for our study of alternative locality configurations. Some urged us to expedite any changes while other commenters requested that we take a cautious approach.

Several commenters who supported the adoption of an MSA-based PFS locality structure suggested that option 3 could be used as a transition to the CMS CBSA locality configuration (option 1). Many commenters from the State of California supported option 3 (Separate High Cost MSAs) because the commenters believe it would improve payment accuracy (over the current locality configuration) and mitigate possible payment reductions to rural areas as compared to option 1 (CMS CBSA) and option 4 (Statewide Tiers. Because of the payment reductions to rural areas, most commenters did not support option 4 (Statewide Tiers).

Many commenters also acknowledged the significant redistribution of payments that would occur under each option and requested that we minimize the payment discrepancy between urban and rural areas to ensure continued access to services. One medical association stated that ''budget neutral redistributions would only exacerbate an already flawed and under-funded Medicare PFS'' and suggested that States with a Statewide locality be given the option of remaining a Statewide locality. The commenter also requested that we continue our policy of allowing any State the option of converting to a Statewide locality.

For a more detailed discussion of the comments submitted on the interim locality study, see the CY 2010 PFS proposed rule (74 FR 33534).

We did not make a specific proposal for changing the PFS locality structure in the CY 2010 PFS proposed rule. As noted by the commenters and reflected in the report, significant payment redistribution would occur if a nationwide change in the PFS locality configuration were undertaken. All four of the potential alternative payment locality configurations reviewed in the report would increase the number of localities and separate higher cost,

typically urban areas from lower cost, typically rural ''Rest of State'' areas. In general, payments to urban areas would increase while rural areas would see a decrease in payment under each of the options studied because they would no longer be grouped with higher cost ''urbanized'' areas. We intend to continue our review of the suggestions made by the commenters and consider the impact of each of the potential alternative locality configurations.

Comment: We received some comments on the locality discussion from various specialty groups and medical societies. A few commenters expressed support for our decision to defer proposing changes to the PFS locality reconfiguration and recommended that we continue pursuing a cautious approach. One State Medical Association stated that it is hopeful that the Congress will provide a method to update all payment localities in a manner that prevents cuts to payments in lower-cost counties. However, in the event the Congress does not provide additional funding to hold lower cost counties harmless, the commenter supports a PFS locality configuration based on MSAs. Another commenter noted that the redistribution of payments could have a negative impact on access to care. The commenter stated that geographic location should not be a detriment as to whether a physician can provide care to a Medicare beneficiary. One specialty group stated that changes in localities should only be made to improve the relative accuracy of Medicare payment. In the event we make a proposal to change the PFS locality structure, the commenter urged us to provide sufficient data for the public to ascertain the impact on specific geographic areas.

Response: We agree that a nationwide locality reconfiguration requires a cautious approach and will carefully consider the commenter's suggestion regarding an MSA-based locality configuration. We would also like to thank the public again for the many thoughtful comments on the interim locality study report entitled, ''Review of Alternative GPCI Payment Locality Structures''. A final report will be posted to the CMS Web site after further review of the studied alternative locality approaches. As explained in the CY 2010 PFS proposed rule, we are not proposing changes in the PFS locality structure at this time. In the event we decide to make a specific proposal for changing the locality configuration, we would provide data on the impact of the changes. We would also provide extensive opportunities for public input (for example, Town Hall meetings or Open Door Forums, as well as opportunities for public comments afforded by the rulemaking process).

C. Malpractice Relative Value Units (RVUs)

1. Background

Section 1848(c) of the Act requires that each service paid under the PFS be comprised of three components: Work, PE, and malpractice. From 1992 to 1999, malpractice RVUs were charge-based, using weighted specialty-specific malpractice expense percentages and 1991 average allowed charges. Malpractice RVUs for new codes after 1991 were extrapolated from similar existing codes or as a percentage of the corresponding work RVU. Section 4505(f) of the BBA required us to implement resource-based malpractice RVUs for services furnished beginning in 2000. Initial implementation of resource-based malpractice RVUs occurred in 2000. The statute also requires that we review, and if necessary adjust, RVUs no less often than every 5 years. The first review and update of resource based malpractice RVUs was addressed in the CY 2005 PFS final rule (69 FR 66263). Minor modifications to the methodology were addressed in the CY 2006 PFS final rule (70 FR 70153). In the CY 2010 PFS proposed rule, we proposed to implement the second review and update of malpractice RVUs.

2. Methodology for the Revision of Resource-Based Malpractice RVUs

The proposed malpractice RVUs were developed by Acumen, LLC (Acumen) under contract to us (74 FR 33537).

The methodology used in calculating the proposed second review and update of resource-based malpractice RVUs largely parallels the process used in the CY 2005 update. The calculation requires information on malpractice premiums, linked to the physician work conducted by different specialties that furnish Medicare services. Because malpractice costs vary by State and specialty, the malpractice premium information must be weighted geographically and across specialties. Accordingly, the malpractice expense RVUs that we proposed are based upon three data sources:

- Actual CY 2006 and CY 2007 malpractice premium data.
- CY 2008 Medicare payment data on allowed services and charges.
- CY 2008 Geographic adjustment data for malpractice premiums.

Similar to the previous update of the resource-based malpractice expense RVUs, we proposed to revise the RVUs using specialty-specific malpractice premium data because they represent the actual malpractice expense to the physician. In addition, malpractice premium data are widely available through State Departments of Insurance. We proposed to use actual CY 2006 and CY 2007 malpractice premium data because they are the most current data available (CY 2008 malpractice premium data were not consistently available during the data collection process). Accounting for market share, three fourths of all included rate filings were implemented in CY 2006 and CY 2007. The remaining rate filings were implemented in CY 2003 through CY 2005 but still effective in CY 2006 and CY 2007. Carriers submit rate filings to their State Departments of Insurance listing the premiums and other features of their coverage. The rate filings include an effective date, which is the date the premiums go into effect. Some States require premium changes to be approved before their effective date; others just require the rate filings to be submitted. We attempted to capture at least 2 companies and at least 50 percent of the market share, starting with the largest carriers in a State.

The primary determinants of malpractice liability costs continue to be physician specialty, level of surgical involvement, and the physician's malpractice history. We collected malpractice premium data from 49 States and the District of Columbia for all physician specialties represented by major insurance providers. Rate filings were not available through Departments of Insurance in Mississippi or Puerto Rico. Premiums were for $1 million/$3 million, mature, claims-made policies (policies covering claims made, rather than services furnished during the policy term). A $1 million/$3 million liability limit policy means that the most that would be paid on any claim is $1 million and that the most that the policy would pay for several claims over the timeframe of the policy is $3 million. We collected data from commercial and physician-owned insurers and from joint underwriting associations (JUAs). A JUA is a State government-administered risk pooling insurance arrangement in areas where commercial insurers have left the market. Adjustments were made to reflect mandatory surcharges for patient compensation funds (PCFs) (funds to pay for any claim beyond the statutory amount, thereby limiting an individual physician's liability in cases of a large suit) in States where PCF participation is mandatory. We sought to collect premium data representing at least 50

percent of physician malpractice premiums paid in each State as identified by State Departments of Insurance and by the National Association of Insurance Commissioners (NAIC).

Rather than select the top 20 physician specialties as we did when the malpractice RVU were originally established and updated, we included premium information for all physician and surgeon specialties, and risk classifications available in the collected rate filings. Most insurance companies provided crosswalks from insurance service office (ISO) codes to named specialties; we matched these crosswalks to CMS specialty codes. We also preserved information obtained regarding surgery classes, which are categorizations that affect premium rates. For example, many insurance companies grouped general practice physicians into nonsurgical, minor-surgical and major-surgical classes, each with different malpractice premiums. Some companies provided additional surgical subclasses; for example, distinguishing general practice physicians that conducted obstetric procedures, which further impacted malpractice rates. We standardized this information to CMS specialty codes.

We proposed a resource based methodology for developing malpractice RVUs for technical component (TC) services (for example diagnostic tests). Currently, the MP RVUs for TC services and the TC portion of global services are based on historical allowed charges and have not been made resource based due to a lack of available malpractice premium data for nonphysician suppliers. Over the last few years, we have requested malpractice premium data for nonphysician suppliers, but had not received any data prior to last year. In response to our request in last year's rulemaking cycle, one commenter did provide information on one of the largest insurance companies that provides liability insurance for medical physicists employed by imaging facilities. After our contractor, Acumen, verified the medical physicist premium information submitted in response to last year's proposed rule, we proposed to use the medical physicist premium data as a proxy for the malpractice premiums paid by all entities providing TC services; primarily independent diagnostic testing facilities (IDTFs).

Other than the change in methodology for developing malpractice RVUs for TC services, our proposed methodology for updating malpractice RVUs conceptually followed the same approach, with some minor refinements, used to originally develop the resource based malpractice RVUs in CY 2000 and used in the CY 2005 update. These refinements included an expansion in the malpractice premium data collection to include additional specialties, a distinction between major and minor surgical risk factors, and a proposal to use the malpractice risk factor of the specialty that performs a given service the most (dominant specialty) for services with less than 100 occurrences. We solicited comments on our proposed methodology for updating the malpractice RVUs and posted the Acumen report, ''Interim Report on Malpractice RVUs for the CY 2010 Medicare Physician Fee Schedule Proposed Rule'' on the CMS Web site. The interim report on Malpractice RVUs for the CY 2010 PFS proposed rule and Malpractice premium amounts and risk factors by specialty, which was produced by Acumen, LLC under contract to CMS, is accessible from the CMS PFS Web page under the heading ''Interim Report on Malpractice RVUs for the CY 2010 Medicare PFS Proposed rule.'' The report and malpractice premiums may also be accessed directly on the CMS Web site at *http://www.cms.hhs.gov/PhysicianFeeSched/05_Malpractice_Report.asp#TopOfPage.*

A more detailed explanation of our proposed malpractice RVU update can be found in the CY 2010 PFS proposed rule (74 FR 33537).

We received over 250 industry comments on the CY 2010 proposed malpractice RVU update.

Comment: Many commenters commended us for employing an expanded data collection that included premium information for all physician specialties, rather than just the top 20 Medicare physician specialties. Commenters also applauded our use of the most current PLI premium data available from State filings.

Response: We agree with the commenters that the use of the most current PLI data and the expanded data collection is appropriate.

Comment: Some commenters supported the use of medical physicist data as a proxy for developing malpractice RVUs for TC services. The commenters expressed their belief that using medical physicist data provide a better reflection of PLI premiums paid by entities furnishing TC services than the current charge-based approach or cross-walking to physician specialties. Many commenters did not support the proposed change to resource-based MP RVUs for TC services because premium amounts paid by medical physicists were used as a proxy for all entities furnishing TC services. The commenters objected to our proposed use of medical physicist data, stating that the use of this data will result in inappropriately low MP RVUs for the affected services. The commenters indicated that we should use premium data from the suppliers of these TC services, such as IDTFs and audiologists. Some commenters requested that we work with the Radiology Business Management Association (RBMA) to obtain PLI premium information for IDTFs. Other suppliers of TC services, including suppliers of imaging services and remote cardiac monitoring services, also submitted liability policy information. Several commenters requested that we use the current charge-based malpractice RVUs until data from TC suppliers can be collected.

Response: We appreciate all the comments received on this issue. While we agree with the commenters who stated that the medical physicist data provide a better reflection of PLI premiums paid by entities furnishing TC services than the current charge-based approach or crosswalking to physician specialties, we also agree with the commenters who indicated that we should use premium data from the suppliers of these services, if the data are available and meet the same standards as the other premium data collected for use in the development of the malpractice RVUs. As noted earlier, we have repeatedly requested PLI data sources for suppliers of TC services. Our proposal for TC services was based on the first verifiable data source provided to us. In the comment period, alternative PLI sources were recommended for use with the TC services. In some circumstances, the information submitted by the commenters included insurance coverage beyond the scope of the malpractice RVUs (for example, property liability, errors and omissions liability) and/or coverage limits beyond the $1 million/$3 million coverage malpractice premium collection parameters used for professional services. However, these same commenters also submitted the names of several insurance companies who provide malpractice insurance for IDTFs. We contacted these insurance companies in an attempt to collect premium data for the suppliers of TC services. We were able to verify the premium information for IDTFs consistent with the information collected for physician specialties. Therefore, we are using this verified premium data in the calculation of the malpractice RVUs for TC services.

Comment: Many commenters stated that all services have some level of malpractice risk and that it was

inappropriate for CMS to allow rounding to result in zero malpractice RVUs for some services.

Response: After considering the comments on this issue, we agree that it would be inappropriate for services to receive zero payment for malpractice due to rounding. These services will be assigned 0.01 malpractice RVUs for CY 2010.

Comment: One commenter did not support the use of work RVUs to account for differences in risk-of-service for drug administration services and that these services were being inappropriately penalized in the malpractice risk allocation.

Response: When developing the current resource-based PE RVU methodology, we received similar comments since the work RVUs are also a component of the indirect PE allocation. In response to those comments, we modified the resource-based PE methodology to allow the allocation to be done using the greater of the clinical labor involved in the service or the work RVUs. In light of similar comments on this issue in the malpractice allocation, we will make a similar modification. Specifically, we will use the greater of the clinical labor involved in the service or the work RVUs in the malpractice allocation.

Comment: The AMA RUC and other commenters requested that we use the generally lower malpractice survey data from the Physician Practice Information Survey (PPIS) for NPPs instead of crosswalking NPPs to the lowest *physician* specialty (allergy/immunology). One commenter also noted that the average premiums collected for diagnostic radiology were lower than the average reported premium from the AMA PPIS data.

Response: The resource-based malpractice RVUs are based on verifiable PLI premium data. We do not believe it would be appropriate to base the malpractice RVUs for nonphysician specialties or selected specialties on survey data and use premium data for all other specialties. Therefore, we do not agree with the commenters who suggested the use of survey data for NPPs or selected specialties.

Comment: The AMA RUC and two other commenters requested that we crosswalk gynecologic oncology to general surgery and surgical oncology (instead of crosswalking it to medical oncology) because gynecologic oncologists are predominantly cancer surgeons.

Response: We agree with the commenters and will crosswalk gynecologic oncology to general surgery premium data.

Comment: Some commenters raised questions about our proposal to crosswalk maxillofacial surgery and oral surgery to allergy/immunology. The commenters suggested that we use PLI data collected from the American Association of Maxillofacial Surgery (AAOMS) or the PPIS data instead of crosswalking to the lowest physician specialty.

Response: As noted earlier, the resource-based malpractice RVUs are based on verifiable premium data. We do not agree with the commenters who suggested the use of unverified maxillofacial surgery and oral surgery PLI information. However, we do agree that it would be more appropriate to use a surgical specialty's premium data rather than allergy/immunology premium data for surgical specialties. Therefore, we will crosswalk these specialties to the similar specialty of plastic surgery.

Comment: Some commenters did not support using the global surgery indicator for assigning the major or minor risk factor to surgical procedures. The commenters stated that using this methodology for determining the surgical class will not adequately address all the instances in which a surgical procedure should be classified as major. The commenters requested that we work with PLI insurance companies and the AMA RUC to determine a more comprehensive definition of major and minor surgical classifications. One commenter requested that we assign the surgical risk factor to injection procedures performed during cardiac catheterization as described by CPT codes 93501 through 93572.

Response: For the original implementation of resource-based MP RVUs (CY 2000), we assigned one of two risk factors to each service based on code range: surgery and nonsurgery (the surgery risk factor did not distinguish between major and minor). This methodology of assigning risk factors to specific services was also used in the first Five-Year Review. For the second malpractice RVU update, we proposed to assign each service code to one of the following three risk factors: Nonsurgical; minor surgical; and major surgical (74 FR 33539). Risk factor classes for each service were assigned based on procedure code ranges and whether or not the service had a 90-day global period. The 90-day global period was used to assign surgical codes to major surgery.

After consideration of the comments, we will not finalize our proposal but will continue to use our current approach for assigning risk factors to individual services while we study this issue further. We will consider the request to assign the surgical risk factor to injection procedures as part of our further study and would propose any changes through future rulemaking.

As is done under the current methodology, we will continue to assign each service to either a nonsurgical or surgical risk factor based on CPT code ranges: Surgery (CPT code range 10000 through 69999; 92980 through 92998; 93501 through 93536; 92973 through 92974; 93501 through 93533; 93580 through 93581; 93600 through 93613; 93650 through 93652; 92975; 92980 through 92998; 93617 through 93641); and nonsurgery (all other CPT codes). Consistent with current practice, the surgery risk factor would not distinguish between major and minor.

Comment: While commenters agreed with most of our proposed claims based dominant specialty designations for codes with less than 100 allowed services, the commenters disagreed with our proposal for some services. The commenters believe that the claims have been miscoded, resulting in erroneous specialty designations.

Response: Service specific malpractice RVUs are determined based on the weighted average risk factor(s) of the specialties that furnish the service. For rarely-billed Medicare services (that is, when allowed services are less than 100), we proposed to use the risk factor of the dominant specialty as reflected in our claims data. In the past, we had used all the specialties performing these low volume services as reflected in our claims data. Approximately 2,000 services met the criteria for ''low volume.'' The dominant specialty for each 'low volume' service was determined from CY 2008 Medicare claims data.

By using the dominant specialty from our claims data to assign the specialty for these low volume services, we attempted to strike a balance between our preference for the empirical, objective use of all of our claims data in the development of the malpractice RVUs and the desire of commenters to override our claims data for these low volume services using less objective criteria. After careful consideration of the comments, we continue to believe that a more balanced approach between the complete reliance on all of the specialties in our claims data and the subjective review of each low volume service is the most appropriate way of approaching the development of malpractice RVUs for these low volume services. We disagree with the commenters that we should override the dominant specialty from the claims data

with the recommended specialty. Therefore, we will finalize our proposal to use Medicare claims data to assign a dominant specialty to low volume services.

D. Medicare Telehealth Services

1. Requests for Adding Services to the List of Medicare Telehealth Services

Section 1834(m)(4)(F) of the Act defines telehealth services as professional consultations, office visits, and office psychiatry services, and any additional service specified by the Secretary. In addition, the statute requires us to establish a process for adding services to or deleting services from the list of telehealth services on an annual basis.

In the December 31, 2002 **Federal Register** (67 FR 79988), we established a process for adding services to or deleting services from the list of Medicare telehealth services. This process provides the public with an ongoing opportunity to submit requests for adding services. We assign any request to make additions to the list of Medicare telehealth services to one of the following categories:

- *Category #1:* Services that are similar to professional consultations, office visits, and office psychiatry services. In reviewing these requests, we look for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. We also look for similarities in the telecommunications system used to deliver the proposed service, for example, the use of interactive audio and video equipment.
- *Category #2:* Services that are not similar to the current list of telehealth services. Our review of these requests includes an assessment of whether the use of a telecommunications system to deliver the service produces similar diagnostic findings or therapeutic interventions as compared with the face-to-face ''hands on'' delivery of the same service. Requestors should submit evidence showing that the use of a telecommunications system does not affect the diagnosis or treatment plan as compared to a face-to-face delivery of the requested service.

Since establishing the process, we have added the following to the list of Medicare telehealth services: psychiatric diagnostic interview examination; ESRD services with two to three visits per month and four or more visits per month (although we require at least one visit a month to be furnished in-person ''hands on'', by a physician, clinical nurse specialist (CNS), nurse practitioner (NP), or physician assistant (PA) to examine the vascular access site); individual medical nutrition therapy; neurobehavioral status exam; and follow-up inpatient telehealth consultations.

Requests to add services to the list of Medicare telehealth services must be submitted and received no later than December 31 of each calendar year to be considered for the next rulemaking cycle. For example, requests submitted before the end of CY 2009 are considered for the CY 2011 proposed rule. Each request for adding a service to the list of Medicare telehealth services must include any supporting documentation you wish us to consider as we review the request. Because we use the annual PFS rulemaking process as a vehicle for making changes to the list of Medicare telehealth services, requestors should be advised that any information submitted is subject to disclosure for this purpose. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, visit our Web site at *http://www.cms.hhs.gov/telehealth/.*

2. Submitted Requests for Addition to the List of Telehealth Services

We received requests in CY 2008 to add the following services as Medicare telehealth services effective for CY 2010: (1) Health and behavior assessment and intervention (HBAI) procedures; and (2) nursing facility services. In addition, we received a number of requests to add services that we did not approve as Medicare telehealth services in previous PFS rules. These requested services include critical care services; initial and subsequent hospital care; group medical nutrition therapy; diabetes self-management training; speech and language pathology services; and physical and occupational therapy services.

In the CY 2010 PFS proposed rule (74 FR 33543), we responded to these requests. We proposed to add individual HBAI services to the list of Medicare telehealth services, and we proposed to revise our regulations at § 410.78 and § 414.65 accordingly. We proposed to revise § 410.78 to restrict physicians and practitioners from using telehealth to furnish the physician visits required under § 483.40(c). We proposed to revise § 410.78 to specify that the G-codes for follow-up inpatient telehealth consultations (as described by HPCPCS codes G0406 through G0408) include follow-up telehealth consultations furnished to beneficiaries in hospitals and SNFs. We did not propose to add group HBAI, family-with-patient HBAI, nursing facility services, critical care services, or any of the other requested services to the list of Medicare telehealth services. The following is a summary of the discussion from the proposed rule, a summary of comments we received, and our responses.

a. Health and Behavior Assessment and Intervention (HBAI)

The American Psychological Association (APA) submitted a request to add HBAI services (as described by HCPCS codes 96150 through 96154) to the list of approved telehealth services. The APA asked us to evaluate and approve HBAI services as a Category #1 service because they are comparable to the psychotherapy services currently approved for telehealth.

As discussed in the CY 2010 PFS proposed rule (74 FR 33543), clinical psychologists furnish HBAI services to beneficiaries to help them manage or improve their behavior in response to physical problems. Elements of HBAI services typically include interviewing, observing, and counseling beneficiaries to help them modify their behavior. These elements are also common to the office psychiatry services currently approved for telehealth. In the proposed rule, we stated that we believe the interaction between a practitioner and a beneficiary receiving individual HBAI services (as described by HCPCS codes 96150 through 96152) is similar to the assessment and counseling elements of the individual office psychiatry services currently approved for telehealth. Therefore, we proposed to revise § 410.78 and § 414.65 to include individual HBAI services as Medicare telehealth services.

With regard to group HBAI (as described by HCPCS code 96153) or family-with-patient HBAI (as described by HCPCS code 96154), we noted that group services are not currently approved as Medicare telehealth services. Group counseling services have a different interactive dynamic between the physician or practitioner and his or her patients as compared to individual services. Since the interactive dynamic for group HBAI services is not similar to that for individual HBAI services or any other approved telehealth services, we stated that we do not believe that group HBAI or family-with-patient HBAI services should be considered as Category #1 requests. To be considered as a Category #1 request, a service must be similar to the current list of Medicare telehealth services. (See 70 FR 45787 and 70157, and 73 FR 38516 and 69743). Instead,

we believe that group HBAI and family-with-patient HBAI must be evaluated as Category #2 services. Accordingly, we need to evaluate whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. The requestor did not submit evidence suggesting that the use of a telecommunications system to deliver these services would produce similar diagnostic findings or therapeutic interventions as compared to the face-to-face delivery of these services. Therefore, we did not propose to add group HBAI (as described by HCPCS code 96153) or family-with-patient HBAI (as described by HCPCS code 96154) to the list of approved Medicare telehealth services.

Comment: The APA stated that it was pleased that we proposed to add individual HBAI to the list of approved telehealth services and that it may wish to resume the discussion of adding other HBAI services in the future. Other commenters were also pleased that we proposed to add individual HBAI to the list of approved telehealth services. However, they disagreed with our proposal not to add the other HBAI services to the list of approved Medicare telehealth services. The commenters noted that CMS has no evidence that it is not appropriate to furnish group services via telehealth. In addition, the commenters believe that the involvement of family members in patient counseling can often be critical in developing an appropriate plan of care.

Response: Office psychiatry services currently approved for telehealth are individual rather than group services. There are no group services approved for telehealth. In order to add services for Medicare telehealth that are not similar to the existing list of Medicare telehealth services, we evaluate comparative studies to assess whether the use of an interactive audio and video telecommunications system is an adequate substitute for the in-person (face-to-face) delivery of the requested service. Requestors did not submit sufficient comparative analyses showing that the use of a telecommunications system is an adequate substitute for group counseling services furnished in person.

b. Nursing Facility Services

Section 149 of the MIPPA added SNFs as telehealth originating sites effective for services furnished on or after January 1, 2009. We received a request from the American Telemedicine Association (ATA) to add subsequent nursing facility care; nursing facility discharge services; and other nursing facility services to the list of approved telehealth services. The Center for Telehealth and e-Health Law submitted a request to add the same nursing facility services and indicated its support of ATA's request. We also received a request from the Marshfield Clinic to add the same services requested by the ATA, plus the initial nursing facility care services.

The procedure codes included in these requests are used to report evaluation and management (E/M) services furnished onsite to patients in SNFs. The requestors drew analogies to the E/M services currently approved for Medicare telehealth, and they provided evidence in support of their belief that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care.

As discussed in the CY 2010 PFS proposed rule (74 FR 33543), the long-term care regulations at § 483.40 require that residents of SNFs receive initial and periodic personal visits. These regulations insure that at least a minimal degree of personal contact between a physician or a qualified NPP and a resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay. We believe that these Federally-mandated visits should be conducted in-person, and not as Medicare telehealth services. We proposed to revise § 410.78 to restrict physicians and practitioners from using telehealth to furnish the physician visits required under § 483.40(c).

We reviewed the use of telehealth for each of the subcategories of nursing facility services included in these requests. We identified the E/M services that fulfill Federal requirements for personal visits under § 483.40 and we did not propose to add any procedure codes that are used exclusively to describe these Federally-mandated visits.

Initial Nursing Facility Care

The initial nursing facility care procedure codes (as described by HCPCS codes 99304 through 99306) are used to report the initial E/M visit in a SNF or NF that fulfills Federally-mandated requirements under § 483.40(c). We did not propose to add the initial nursing facility care services (as described by HCPCS codes 99304 through 99306) to the list of approved Medicare telehealth services because these procedure codes are used exclusively to describe E/M services that fulfill Federal requirements for personal visits under § 483.40.

Subsequent Nursing Facility Care

The subsequent nursing facility care procedure codes (as described by HCPCS codes 99307 through 99310) are used to report either a Federally-mandated periodic visit under § 483.40(c), or any E/M visit, prior to and after the initial physician visit, that is reasonable and medically necessary to meet the medical needs of the individual resident. In the past, we have not added hospital E/M visits to the list of approved Medicare telehealth services because of our concern regarding the use of telehealth for the ongoing E/M of a high-acuity hospital inpatient. (See 69 FR 47511, 69 FR 66276, 72 FR 38144, 72 FR 66250, 73 FR 38517, and 73 FR 69745.) Many residents of SNFs also require medically complex care, and we have similar concerns about allowing physicians or NPPs to furnish E/M visits via telehealth to residents of SNFs.

The complexity of care required by many residents of SNFs may be significantly greater than the complexity of care generally associated with patients receiving the office visits approved for telehealth. Accordingly, we do not consider E/M visits furnished to residents of SNFs similar to the office visits on the current list of Medicare telehealth services. Therefore, we believe the use of subsequent nursing facility care for medically necessary E/M visits that are in addition to Federally-mandated periodic personal visits must be evaluated as a Category #2 service.

We evaluated whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. The requestors submitted supporting documentation to demonstrate that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care. However, we did not receive sufficient comparative analysis or other compelling evidence to demonstrate that furnishing E/M visits via telehealth to residents of SNFs is an adequate substitute for the face-to-face encounter between the practitioner and the resident, especially in cases where the resident requires medically complex care. We were also concerned that one study demonstrated that services provided via telehealth do not elicit adequate participation in informed medical decision-making from residents with low to moderate illness when compared to face-to-face encounters. We determined that telehealth is not an adequate substitute for the face-to-face delivery of E/M visits to residents of SNFs. Therefore, we did not propose to

add subsequent nursing facility care services to the list of approved Medicare telehealth services.

Nursing Facility Discharge Day Management

The nursing facility discharge day management codes (as described by HCPCS codes 99315 and 99316) are used to report an E/M visit that prepares a resident for discharge from a nursing facility. We note that there is no Medicare Part B requirement to furnish and bill an E/M visit in preparation for a resident's discharge from a SNF. However, if a physician or qualified NPP bills a Nursing Facility Discharge Services code, we believe that a face-to-face encounter will better insure that the resident is prepared for discharge. We do not have evidence that nursing facility discharge services furnished via telehealth are equivalent to face-to-face provision of this service. We did not propose to add the nursing facility discharge day management services to the list of approved Medicare telehealth services.

Other Nursing Facility Service

In 2006, CPT added a procedure code for Other Nursing Facility Service (CPT code 99318) to describe an annual nursing facility assessment. An annual assessment is not one of the required visits under the long-term care regulations at § 483.40. For Medicare purposes, this code can be used in lieu of a Subsequent Nursing Facility Care code to report a Federally-mandated periodic personal visit furnished under § 483.40(c). An annual assessment visit billed using CPT code 99318 does not represent a distinct benefit service for Medicare Part B physician services, and it cannot be billed in addition to the required number of Federally-mandated periodic personal visits. Under Medicare Part B, we cover this procedure code if the visit fully meets the CPT code 99318 requirements for an annual nursing facility assessment. In order to cover and pay for this service, we also require that this annual assessment falls on the 60-day mandated visit cycle. We did not propose to add the other nursing facility care services described by this code to the list of approved Medicare telehealth services because this code is payable by Medicare only if the visit is substituted for a Federally-mandated visit under § 483.40(c). We believe all of the Federally-mandated periodic visits must be conducted in person.

Follow-up Inpatient Consultations

Prior to 2006, follow-up inpatient consultations (as described by CPT codes 99261 through 99263) were approved telehealth services. In 2006, the CPT Editorial Panel of the American Medical Association (AMA) deleted the codes for follow-up inpatient consultations. In the hospital setting, the AMA advised practitioners to bill for services that would previously have been billed as follow-up inpatient consultations using the procedure codes for subsequent hospital care (as described by CPT codes 99231 through 99233). In the nursing facility setting, the AMA advised practitioners to bill for these services using the procedure codes for subsequent nursing facility care (as described by CPT codes 99307 through 99310).

In the CY 2009 PFS final rule with comment period (73 FR 69745), we created follow-up inpatient telehealth consultation codes (as described by HCPCS codes G0406 through G0408) to furnish care to hospital inpatients, and we added these G-codes to the list of Medicare telehealth services. These HCPCS codes are limited to the range of services included in the scope of the previous CPT codes for follow-up inpatient consultations, and the descriptions limit the use of such services for telehealth.

In the CY 2010 PFS proposed rule (74 FR 33547), we stated that if the former codes for follow-up consultations (as described by CPT codes 99261 through 99263) still existed, these procedure codes would also be available to practitioners providing follow-up consultations via telehealth to SNF patients. Although we did not receive a public request to add follow-up inpatient consultations for SNF patients to the list of approved Medicare telehealth services, we stated that we also recognized a need to establish a method for practitioners to provide these services. For CY 2010, we proposed to revise § 410.78 to specify that the G-codes for follow-up inpatient telehealth consultations (as described by HCPCS codes G0406 through G0408) include follow-up inpatient telehealth consultations furnished to beneficiaries in SNFs, as well as in hospitals. The HCPCS codes clearly designate these services as follow-up consultations provided via telehealth, and not as subsequent care used for E/M visits. Utilization of these codes for patients in SNFs will facilitate payment for these services, as well as enable us to monitor whether the codes are used appropriately. (See the CMS Internet-Only Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190, for the definition of follow-up inpatient telehealth consultations.)

The following is a summary of the comments we received regarding our proposed decisions on Nursing Facility Services.

Comment: Commenters supported our proposal to restrict physicians and practitioners from using telehealth to furnish the physician visits required under § 483.40(c). Commenters also supported our proposal to expand the definition of Follow-Up Inpatient Telehealth Consultations (as described by HCPCS codes G0406–G0408) to allow their use for residents of SNFs. Commenters noted that this change would be a positive step towards increasing access to care for Medicare beneficiaries in rural areas.

Some commenters disagreed with our proposal not to add Nursing Facility Services to the list of approved Medicare telehealth services. Commenters acknowledged Congressional intent expressed in section 413 of the MMA that the use of telehealth should not be a substitute for the Federally-mandated periodic personal visits required under § 483.40(c). All commenters agreed with our proposal not to add any procedure codes that are used exclusively to describe these Federally-mandated visits. Commenters stated that they believed that the Congress intended to allow the use of telehealth to furnish E/M medically necessary visits onsite to residents of SNFs that are in addition to Federally-mandated periodic personal visits. Some commenters also noted that due to health professional shortages in rural areas, many SNFs lack essential onsite services. Some commenters believe adding nursing facility visits to the list of approved telehealth services will improve the quality of care furnished to residents of SNFs. Commenters also noted that not adding nursing facility visits to the list of approved Medicare telehealth services will not prevent the use of telehealth to furnish services to residents of SNFs, including those residents requiring medically complex care. These same residents could be transported to physicians' offices or hospitals where they could receive similar E/M visits via telehealth.

Response: We did not receive sufficient comparative analysis or other compelling evidence to demonstrate that furnishing E/M visits via telehealth to residents of SNFs is an adequate substitute for the face-to-face encounter between the practitioner and the resident, especially in cases where the resident requires medically complex care. We are further concerned that the use of telehealth may not elicit adequate participation from residents of SNFs in

making informed medical decisions with their clinicians when compared to face-to-face encounters.

We agree with the commenters who noted that expanding the definition of Follow-Up Inpatient Telehealth Consultations (G0406–G0408) to allow their use for residents of SNFs will increase access to care for Medicare beneficiaries in rural areas. We believe the availability of inpatient consultations to furnish care via telehealth to residents of SNFs is consistent with the addition of SNFs as approved telehealth originating sites. Physicians and NPPs who furnish inpatient consultations via telehealth complement the care provided by the SNF and furnished onsite by the attending physician or physician of record.

c. Critical Care Services

In the CY 2009 PFS final rule with comment period (73 FR 69744), we did not add critical care services to the list of approved Medicare telehealth services. In 2009, Philips Healthcare submitted an expanded request to add critical care services to the list of approved Medicare telehealth services. It stated that critical care services can be approved as a Category #1 service based on their similarity to the inpatient consultation services currently approved for Medicare telehealth. The requestor also stated that many of the components of critical care are similar to a high-level inpatient consultation service, which is currently approved for Medicare telehealth. Common components include obtaining a patient history, conducting an examination, and engaging in complex medical decision-making for patients who may be severely ill. Because we classified critical care as a Category #2 service last year, the requestor also submitted evidence to support its belief that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care.

In the CY 2010 PFS proposed rule (74 FR 33548), we stated that remote critical care services are different than the telehealth delivery of critical care (as described by HCPCS codes 99291 and 99292). We did not propose adding critical care services (as described by HCPCS codes 99291 and 99292) to the list of approved Medicare telehealth services. We reiterated that our decision not to add critical care services to the list of approved telehealth services does not preclude physicians from furnishing telehealth consultations to critically ill patients.

Comment: A commenter disagreed with our proposal not to add critical care services to the list of approved Medicare telehealth services. The commenter submitted a new study to support its belief that these services are comparable to critical care furnished in-person. The commenter asserted that the role of the intensivist, whether in-person or remotely, is to provide the required expertise and ability to direct onsite clinical staff to perform any necessary hands-on intervention, not necessarily to effectuate them personally. To support this, the commenter submitted a vignette describing critical care services, including an analysis detailing the types of services furnished when critical care (as described by HCPCS codes 99291 and 99292) was billed by a sample of intensivists. The commenter noted that the critical care services included in this sample did not require hands-on intervention.

Another commenter who submitted the CY 2009 request submitted descriptions of telestroke technology to support the assertion that the elements of a stroke-related neurological assessment performed by a neurologist are effectively the same whether furnished in-person or via telehealth. The commenter acknowledges that some telestroke services satisfy the criteria for billing consultations via telehealth, but noted that the payment is less than the same neurological assessment furnished in-person and billed as a critical care service. The commenter requested that we consider adding critical care services to the list of approved Medicare telehealth services when the underlying diagnosis is stroke-related.

Response: We continue to believe that remote critical care services are different from the telehealth delivery of critical care services (as described by HCPCS codes 99291 and 99292). The AMA created remote critical care tracking codes. Such codes track utilization of a service, facilitating data collection on, and assessment of, new services and procedures. We believe that the data collected for these tracking codes will help provide useful information on how to best categorize and value remote critical care services in the future.

We did not find the studies submitted during the comment period persuasive that telehealth can be an adequate substitute for the face-to-face delivery of critical care services (as described by HCPCS codes 99291 and 99292). As described in these studies, the role of the physician furnishing remote critical care services includes monitoring patients and directing on-site staff to intervene, as necessary. Within the current standards of practice, we believe that critical care services (as described by HCPCS codes 99291 and 99292) require the physical presence of a physician who is available to furnish any hands-on intervention. We continue to believe that remote critical care services are different services than the telehealth delivery of critical care (as described by HCPCS codes 99291 and 99292). As noted above, we believe that the data collected for the remote critical care tracking codes will help provide useful information on how to best categorize and value remote critical care services in the future.

d. Other Requests

We received a number of requests to add services that we reviewed and did not accept in previous PFS Rules. The following are brief summaries of our discussions from the proposed rule, summaries of comments received, and our responses.

Initial and Subsequent Hospital Care

We received a request to add initial hospital care (as described by HCPCS codes 99221 through 99223) and subsequent hospital care (as described by HCPCS codes 99231 through 99233) to the list of approved Medicare telehealth services. In response to previous requests, we did not add initial or subsequent hospital care to the list of approved telehealth services because of our concern regarding the use of telehealth for the ongoing E/M of a high-acuity hospital inpatient. (See 69 FR 47510 and 66276, 72 FR 38144 and 66250, and 73 FR 38517 and 69745.) We did not receive any new information with this request that would alter our previous decision. Therefore, we did not propose adding initial hospital care or subsequent hospital care to the list of approved Medicare telehealth services. We did not receive any comments on this proposal.

Group Medical Nutrition Therapy Services

We received a request to add group medical nutrition therapy (MNT) services (as described by HCPCS codes G0271 and 97804) to the list of approved Medicare telehealth services. In response to a previous request, we did not add group MNT to the list of approved telehealth services because we believe that group services are not appropriately delivered through telehealth. (See 70 FR 45787 and 70157.) We did not receive any new information with this request that would alter our previous decision. Therefore, we did not propose adding group MNT to the list of approved Medicare telehealth services. We did

not receive any comments on this proposal.

Diabetes Self-Management Training (DSMT)

We received a request to add diabetes self-management training (DSMT) (as described by HCPCS codes G0108 and G0109) to the list of approved telehealth services. In response to previous requests, we did not add DSMT to the list of approved telehealth services because of the statutory requirement that DSMT include teaching beneficiaries to self-administer injectable drugs. Furthermore, DSMT is often performed in group settings and we believe that group services are not appropriately delivered through telehealth. (See 70 FR 45787 and 70157, and 73 FR 38516 and 69743.) We did not receive any new information with this request that would alter our previous decision. Therefore, we did not propose to add DSMT to the list of approved Medicare telehealth services.

Comment: We received two comments opposing our proposal not to add DSMT to the list of approved Medicare telehealth services. The American Association of Diabetes Educators (AADE) agrees that telehealth is not an appropriate venue for initial DSMT when it includes teaching beneficiaries to self-administer injectable drugs. One commenter submitted studies to support its belief that the use of a telecommunications system was equivalent to the face-to-face delivery of follow-up DSMT.

Response: We believe that skill-based training, such as teaching patients how to inject insulin, would be difficult to accomplish effectively without the physical presence of the teaching practitioner. We disagree that this training element should be carved out of individual DSMT for purposes of providing Medicare telehealth services. The training involved in teaching beneficiaries the skills necessary for the self-administration of injectable drugs is a key component of this statutorily described benefit (and therefore inherent in the codes that describe DSMT). We continue to believe that it would not be appropriate to add individual follow-up DSMT to the list of approved Medicare telehealth services.

Speech and Language Pathology Services

We received a request to add various speech and language pathology services to the list of approved telehealth services. Speech-language pathologists are not permitted under current law to furnish and receive payment for Medicare telehealth services. Therefore, we did not propose to add any speech and language pathology services to the list of approved Medicare telehealth services. (For further discussion, see 69 FR 47512 and 66276, and 71 FR 48995 and 69657.)

Comment: The American Speech-Language Hearing Association (ASHA) commented that telehealth has been successfully applied to speech-language pathology and audiology services. ASHA requested that CMS support expansion of Medicare telehealth coverage for speech-language pathologists in communications with Congress. The American Academy of Audiology commented on the shortage of audiologists in rural areas. The group requested that we use our administrative authority to add audiology services to the list of approved Medicare telehealth services.

Response: It is not within our administrative authority to pay speech-language pathologists and audiologists for services furnished via telehealth. The statute authorizes the Secretary to pay only for telehealth services furnished by a physician or a practitioner as those terms are defined in the statute.

Physical and Occupational Therapy Services

We received a request to add various physical and occupational therapy services to the list of approved Medicare telehealth services. The statute does not authorize Medicare payment to physical and occupational therapists for Medicare telehealth services. Therefore, we did not propose to add any physical and occupational therapy services to the list of approved Medicare telehealth services. (For further discussion, see 71 FR 48995 and 69657.)

e. Summary: Result of Evaluation of 2010 Requests

We will finalize our proposal to add the individual HBAI services (as described by HCPCS codes 96150 through 96152) and not to add group HBAI (as described by HCPCS code 96153) or family-with-patient HBAI (as described by HCPCS code 96154) to the list of approved Medicare telehealth services. We will also finalize our proposal to add individual HBAI services to the list of approved Medicare telehealth services at § 410.78 and § 414.65.

We will finalize our proposal to revise § 410.78 to restrict physicians and practitioners from using telehealth to furnish the physician visits required under § 483.40(c). We will finalize our proposal not to add Nursing Facility Services (as described by HCPCS codes 99304 through 99318) to the list of approved Medicare telehealth services. We will also finalize our proposal to revise § 410.78 to specify that the G-codes for follow-up inpatient telehealth consultations (as described by HPCPCS codes G0406 through G0408) include follow-up telehealth consultations furnished to beneficiaries in hospitals and SNFs.

We will finalize our proposals not to add critical care services (as described by HCPCS codes 99291 and 99292) or any of the other requested services to the list of approved Medicare telehealth services.

3. Other Issues

We received other comments on matters related to Medicare telehealth services that were not the subject of proposals in the CY 2010 PFS proposed rule. We thank the commenters for sharing their views and suggestions. Because we did not make any proposals regarding these matters, we do not generally summarize or respond to such comments in this final rule. However, we have chosen to summarize and respond to the following comments in order to furnish more information.

Comment: The American Society of Nephrology requested clarification on whether Medicare would pay for kidney disease patient education furnished via telehealth. Other commenters specifically requested that we add kidney disease patient education services to the list of approved telehealth services.

Response: Kidney disease patient education services are not approved Medicare telehealth services. Any interested parties may submit requests to add services to the list of Medicare telehealth services. Requests submitted before the end of CY 2009 will be considered for the CY 2011 PFS proposed rule. Requestors should be advised that each request to add a service to the list of Medicare telehealth services must include any supporting documentation the requestor wishes us to consider as we review the request. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to directly mail these requests, visit our Web site at *http://www.cms.hhs.gov/telehealth*.

Comment: We received a few comments that questioned our criteria and process for reviewing requests to add to the list of approved Medicare telehealth services. The commenters stated that our standards interfere with appropriate physician medical judgment under section 1801 of the Act. One commenter noted that since the

standards are not specified in regulation text, we can change them without formal rulemaking.

Response: Our established criteria and process for reviewing requests to add to the list of approved Medicare telehealth services were subject to full notice and comment procedures in the CY 2003 PFS proposed and final rules. Since we did not make any proposals relating to the criteria or process, any potential revisions to the process for adding or deleting services from the list of approved Medicare telehealth services are outside the scope of this final rule.

Comment: We received a request to provide a list of physician services that can be furnished without an in-person examination.

Response: General guidance regarding physician services that can be furnished by visualizing some aspect of the patient's condition without an in-person examination is provided in the CMS Internet-Only Medicare Benefits Policy Manual, Pub. 100–02, Chapter 15, § 30.

E. Specific Coding Issues Related to the Physician Fee Schedule

1. Canalith Repositioning

In 2008, the CPT Editorial Panel created a new code for canalith repositioning (CRP). This procedure is a treatment for vertigo which involves therapeutic maneuvering of the patient's body and head in order to use the force of gravity to redeposit the calcium crystal debris in the semicircular canal system.

In the CY 2009 PFS final rule with comment period (73 FR 69896), new CPT code 95992, *Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), per day*, was assigned the bundled status indicator (B). We explained that this procedure previously was billed as part of an evaluation and management (E/M) service or under a number of CPT codes, including CPT code 97112, *Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities*. We also explained that because neurologists and therapists are the predominant providers of this service to Medicare patients (each at 22 percent), it was assigned as a ''sometimes therapy'' service under the therapy code abstract file.

After publication of the CY 2009 PFS final rule with comment period, we received comments on this issue from an organization representing physical therapists, as well as others expressing opposition to our decision to bundle the new code. Commenters stated that they believe that our decision to bundle CPT code 95992 was flawed since physical therapists are unable to bill E/M services. One commenter also stated that therapists would be precluded from using another code for billing for this service because CPT correct coding instructions require that the provider/supplier select the procedure that most accurately defines the service provided.

Based upon the commenters' feedback, we realized that we had failed to address how therapists would bill for the service since they cannot bill E/M services. In order to address this situation so that access to this service would not be impacted we released a MedLearn article informing PTs to continue using one of the more generally defined ''always therapy'' CPT codes (97112) as a temporary measure. See *http://www.cms.hhs.gov/transmittals/downloads/R1691CP.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6397.pdf*.

In response to the concerns raised and upon additional review of this issue in the CY 2010 PFS proposed rule, we proposed to change the status indicator for this code from B (Bundled) to I (Not valid for Medicare purposes). We proposed that physicians would continue to be paid for CRP as a part of an E/M service. Physical therapists would continue to use one of the more generally defined ''always therapy'' CPT codes (97112). We stated that we believe that this will enable beneficiaries to continue to receive this service while at the same time it will address our concerns about the potential for duplicate billing for this service to the extent that this service is paid as a part of an E/M service. As a result of this proposal, CPT code 95992 would be removed as a ''sometimes'' therapy code from the therapy code list.

The following is a summary of the comments we received regarding the canalith repositioning proposal.

Comment: Some commenters stated that the canalith repositioning treatment requires 20 minutes of intraservice time as valued by the AMA RUC and that the pre-time was specifically removed because the service is typically performed with an E/M code. The commenters also stated that they believe we expected physicians to forgo payment for CRP and asked that we pay it separately from an E/M service. The commenters requested that CMS recognize the service as separate and distinct from an E/M service.

Response: As we stated in the CY PFS final rule (73 FR 69896) canalith repositioning has been billed using E/M codes and therapy service codes in the past and we believe it should continue to be billed this way. Physicians will continue to be paid for the work performed when CRP is billed using E/M codes.

Comment: Some commenters opposed designating CPT code 95992 as not valid for Medicare purposes. The commenters stated that the code was developed to describe and value CRP and that it should be utilized. Another commenter stated that it is not consistent with CPT coding principles to direct therapists to use a less specific code.

Response: As stated in the CY 2010 PFS proposed rule we initially decided to bundle this code, but upon further review proposed to change the status indicator to ''I'' (not valid for Medicare purposes). Physicians will continue to be paid for CRP as part of an E/M service. Physical therapists will continue to use an ''always therapy'' CPT code as they have in the past. The code will be removed from the ''sometimes'' therapy list. This change will address our concerns about the potential for duplicate billing of this service while still allowing physicians and therapists to perform the service.

Comment: Some commenters are concerned that audiologists have no way to bill for CRP. They requested that CMS reconsider allowing payment to audiologists for this treatment.

Response: Audiological tests are covered under the benefit category for other diagnostic tests. There is no statutory authority to allow audiologists to bill Medicare for treatment services, such as CRP. CRP may be covered under the benefit category for physician services or physical therapy services. If covered as a physician service, it may be furnished incident to a physician's service by any qualified staff.

We will finalize our proposal to designate CPT code 95992 as ''I'', not valid for Medicare purposes. We will also remove it from the ''sometimes'' therapy code list in order to allow therapists to bill appropriately for the service, using one of the more generally defined ''always therapy'' codes.

2. Payment for an Initial Preventive Physical Examination (IPPE)

In the CY 2010 PFS proposed rule, we proposed to increase the payment for an initial preventive physical examination (IPPE) furnished face-to-face with the patient and billed with HCPCS code G0402, *Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment* beginning January 1, 2010. The IPPE service includes a broad array of

components and focuses on primary care, health promotion, and disease prevention.

Section 101(b) of the MIPPA changed the IPPE benefit by adding to the IPPE visit the measurement of an individual's body mass index and, upon an individual's consent, end-of-life planning. Section 101(b) of the MIPPA also removed the screening electrocardiogram (EKG) as a mandatory service of the IPPE.

In order to implement this MIPPA provision, in the CY 2009 PFS final rule with comment period (73 FR 69870), we created HCPCS code G0402 as a new HCPCS code and retained, on an interim basis, the work RVUs of 1.34 assigned to HCPCS code G0344, the code that was previously used to bill for the IPPE. While we did not believe the revisions to the IPPE required by MIPPA impacted the work RVUs associated with this service, we solicited public comments on this issue, as well as suggested valuations of this service to reflect resources involved in furnishing the service. (For a summary of the comments received on the CY 2009 PFS final rule with comment period, see the CY 2010 PFS proposed rule (74 FR 33549)).

Based on a review of the comments received on the CY 2009 PFS final rule with comment period and upon further evaluation of the component services of the IPPE, we stated in the CY 2010 PFS proposed rule that we believe the services, in the context of work and intensity, contained in HCPCS code G0402 are most equivalent to those services contained in CPT code 99204, *Evaluation and management new patient, office or other outpatient visit*, and proposed increasing the work RVUs for HCPCS code G0402 to 2.30 effective for services furnished beginning on January 1, 2010.

The following is a summary of the comments we received regarding the proposed increase to the payment for the IPPE billed with HCPCS code G0402.

Comment: All commenters strongly supported CMS' proposal to increase the payment for the IPPE. Commenters believe that the CY 2010 payment will fairly account for the services rendered.

Response: We are finalizing our proposal to increase the work RVUs for the IPPE to 2.30 effective for services furnished beginning January 1, 2010.

3. Audiology Codes: Policy Clarification of Existing CPT Codes

In the CY 2009 PFS final rule with comment period (73 FR 69890), we noted that the AMA RUC reviewed and recommended work RVUs for 6 audiology codes with which we agreed (that is, CPT codes 92620, 92621, 92625, 92626, 92627, and 92640). We also noted that in the Medicare program, audiology services are covered under the diagnostic test benefit and that some of the work descriptors for these services include ''counseling,'' ''potential for remediation,'' and ''establishment of interventional goals.''

Since audiology services fall under the diagnostic test benefit, aspects of services that are therapeutic or management activities are not payable to audiologists. This distinction is of particular importance since CPT codes 92620, 92621, 92626, 92627, and 92640 are ''timed'' codes. These codes are billed based on the actual time spent furnishing the service.

We noted that we do not believe these aspects fit within the diagnostic test benefit. We solicited comments on this issue. For a summary of the comments received and our responses to those comments, see the CY 2010 PFS proposed rule (74 FR 33550).

The following is summary of the comments we received regarding the policy clarification of existing CPT codes for audiology services.

Comment: We received additional comments reiterating the comments to which we had responded previously in the proposed rule that ''counseling,'' ''potential for remediation,'' and ''establishment of interventional goals'' were part of the diagnostic test and were not therapeutic or management activities. Other commenters agreed with the clarification as it was presented in the proposed rule.

Response: After a careful consideration of all the comments, we are finalizing the clarification of audiology services with respect to CPT codes 92620, 92621, 92625, 92626, 92627, 92640, and other audiologist services as discussed in the proposed rule. Although we understand that test results are sometimes appropriately and briefly conveyed to the patient at the time of the diagnostic test, any therapeutic activities or activities that should be billed as E/M services associated with these audiology codes are not payable to audiologists because they do not fall within the benefit category under which these tests are covered.

4. Consultation Services

a. Background

The current physician visit and consultation codes were developed by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel in November 1990. A consultation service is an evaluation and management (E/M) service furnished to evaluate and possibly treat a patient's problem(s). It can involve an opinion, advice, recommendation, suggestion, direction, or counsel from a physician or qualified NPP at the request of another physician or appropriate source. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.10 A for more information.) A consultation service must be documented and a written report given to the requesting professional. Currently, consultation services are predominantly billed by specialty physicians. Primary care physicians infrequently furnish these services.

The required documentation supports the accuracy and medical necessity of a consultation service that is requested and provided. Medicare pays for a consultation service when the request and report are documented as a consultation service, regardless of whether treatment is initiated during the consultation evaluation service. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.10 B.) A consultation request between professionals may be done orally by telephone, face-to-face, or by written prescription brought from one professional to another by the patient. The request must be documented in the medical record.

In the Physician Fee Schedule Final Rule issued June 5, 1991, (56 FR 25828) we stated that the agency's goal for the development of the new visit and consultation codes was that they meet two criteria: (1) They should be used reliably and consistently by all physicians and carriers; that is, the same service should be coded the same way by different physicians; and (2) they should be defined in a way that enables us to properly crosswalk the new codes to the relative values for the Harvard vignettes so valid RVUs for work are assigned to the new codes.

Based on requests from the physician community to clarify our consultation payment policy and to provide consultation examples, we convened an internal workgroup of medical officers within CMS (then called the Health Care Financing Administration, or HCFA) and revised the payment policy instructions in August 1999 in the Medicare Claims Processing Manual (at § 30.6.10 as cited above). We provided examples of consultation services and examples of clinical scenarios that did not satisfy Medicare criteria for consultation services. Without explicit instructions for every possible clinical scenario outlined in national policy

instructions or in AMA coding definitions or coding instructions, the local policy interpretations by Medicare contractors were not universally equivalent or acceptable to the physician community and resulted in denials in different localities. Some Medicare contractors would consider a consultation service with treatment to be an initial visit rather than a consultation thus resulting in a denial for the billed consultation. We clarified in the 1999 revision that Medicare would pay for a consultation whether treatment was initiated at the consultation visit or not. The physician community has stated that terms such as referral, transfer and consultation, used interchangeably by physicians in clinical settings, confuse the actual meaning of a consultation service and that interpretation of these words varies greatly among members of that community as some label a transfer as a referral and others label a consultation as a referral. Although we clarified the terms referral and consultation in the 1999 revision, there was disagreement with our policy by physicians in the health care community and by AMA CPT staff. We provided our documentation guidance so physicians would be in compliance with our payment policy. The consultation definition in the AMA CPT simply stated that the consultant's opinion or other information must be communicated to the requesting physician.

Additional manual revisions in both January and September 2001 (at § 30.6.10 as cited above) clarified that NPPs can both request and furnish consultation services within their scope of practice and licensure requirements. We continued to explain our documentation requirements to the physician community through our Medicare contractors and in our discussions with the AMA CPT staff. Under our current policy and in the AMA CPT definition, a consultation service must have a request from another physician or other professional and be followed by a report to the requesting professional. The AMA CPT definition does not state that the request must be written in the requesting physician's medical record. However, we require the request to be documented in the requesting physician's plan of care in the medical record as a condition for Medicare payment. The E/M documentation guidelines which apply to all E/M visits or consultations (*http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp*) clearly state that when referrals are made, consultations are requested, or advice is sought, the medical record should indicate to whom and where the referral or consultation is made or from whom the advice is requested. Our Medicare contractors are responsible for reviewing and paying consultation claims when submitted. When there is a question that triggers a review of a consultation service, our Medicare contractors will look at both the requesting physician's medical record (where the request should be noted) and the consultant's medical record where the consultation is reported and at the report generated for the requesting physician. Medicare contractors do not look for evidence of documentation on every claim, only when there is a concern raised during random sampling or during a specific audit performed by a contractor. The AMA CPT coding manual, which is not a payment manual, does not specify these requirements, and, therefore, as we understand it, many physicians do not agree with the CMS policy.

In March 2006, the Office of the Inspector General (OIG) published a report entitled, ''Consultations in Medicare: Coding and Reimbursement'' (OEI–09–02–00030). The stated purpose of the report was to assess whether Medicare's payments for consultation services were appropriate. While the OIG study was being conducted, we continued our ongoing discussions with the AMA CPT staff for potential changes to the consultation definition and guidance in CPT. The findings in the OIG report (based on claims paid by Medicare in 2001) indicated that Medicare allowed approximately $1.1 billion more in 2001 than it should have for services that were billed as consultations. Approximately 75 percent of services paid as consultations did not meet all applicable program requirements (per the Medicare instructions) resulting in improper payments. The majority of these errors (47 percent of the claims reviewed) were billed as the wrong type or level of consultation. The second most frequent error was for services that did not meet the definition of a consultation (19 percent of the claims reviewed). The third category of improperly paid claims was a lack of appropriate documentation (9 percent of the claims reviewed). The OIG recommended that CMS, through our Medicare contractors, should educate physicians and other health care practitioners about Medicare criteria and proper billing for all types and levels of consultations with emphasis on the highest levels and follow-up inpatient consultation services.

We agreed with the OIG findings that additional education would help physicians understand the differences in the requirements for a consultation service from those for other E/M services. With each additional revision from 1999 until the OIG study began, we continually educated physicians through the guidance provided by our Medicare contractors. However, there remained discrepancies with unclear and ambiguous terms and instructions in the AMA CPT definition of a consultation, transfer of care and documentation, and the feedback from the physician community that indicated they disagreed with Medicare guidance.

Prior to the official publication of the OIG report, we issued a Medlearn Matters article, effective January 2006, to educate the physician community about requirements and proper billing for all types and levels of consultation services as requested by the OIG in their report. The Medlearn Matters article reflected the manual changes we made in 2006 and the AMA CPT coding changes as noted below. (This article and related documents can be accessed at *http://www.cms.hhs.gov/MLNMattersArticles/2005MMA/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=7&sortOrder=ascending&itemID=CMS053630&intNumPerPage=2000*.)

Our consultation policy revisions continued as a work-in-progress over several years as disagreements were raised by the physician community. We continued to work with AMA CPT coding staff in an attempt to have improved guidance for consultation services in the CPT coding definition. In looking at physician claims data (for example, the low usage of confirmatory consultation services) and in response to concerns from the physician community regarding how to correctly use the follow-up consultation codes, the AMA CPT Editorial Panel chose to delete some of the consultation codes for 2006. The Follow-Up Inpatient Consultation codes (CPT codes 99261 through 99263) and the Confirmatory Consultation codes (CPT codes 99271 through 99275) were deleted. During our ongoing discussions, the AMA CPT staff maintained that physicians did not fully understand the use of these codes and historically submitted them inappropriately for payment as was reflected in the OIG study.

We issued a manual revision in the Medicare Claims Processing Manual (at § 30.6.10 as cited above) simultaneously with the publication of AMA CPT 2006

coding changes removing the follow-up consultation codes, and instructed physicians to use the existing subsequent hospital care code(s) and subsequent nursing facility care codes for visits following a consultation service. The confirmatory consultation codes (which were typically used for second opinions) were also removed and we instructed physicians to use the existing E/M codes for a second opinion service. We further clarified the documentation requirements by making it easier to document a request for a consultation service from another physician and to submit a consultation report to the requesting professional. Again, physicians stated that a consultant has no control over what a requesting or referring physician writes in a medical record, and that they should not be penalized for the behavior of others. However, our consultation policy instructions apply to all physicians, whether they request a consultation or furnish a consultation. As noted above, documentation by both the requesting physician and the physician who furnishes the consultation is required under the E/M documentation guidelines. The E/M documentation guidelines have been in use since 1995. In our discussions with the AMA CPT staff and physician groups, and national physician open door conference calls, we have emphasized that the requesting physician medical record is not reviewed unless there is a specific audit or random sampling performed. The physician furnishing the consultation service should document in the medical record from whom a request is received.

We continue to hear from the AMA and from specific national physician specialty representatives that physicians are dissatisfied with Medicare documentation requirements and guidance that distinguish a consultation service from other E/M services such as transfer of care. CPT has not clarified transfer of care. Many physician groups disagree with our requirements for documentation of transfer of care. Interpretation differs from one physician to another as to whether transfer of care should be reported as an initial E/M service or as a consultation service.

Despite our efforts, the physician community disagrees with Medicare interpretation and guidance for documentation of transfer of care and consultation. The existing consultation coding definition in the AMA CPT definition has been ambiguous and confusing for certain clinical scenarios and without a clear definition of transfer of care. The CPT consultation codes are used by physicians and qualified NPPs to identify their services for Medicare payment. There has been an absence of any guidance in the AMA CPT consultation coding definition that distinguishes a transfer of care service (when a new patient visit is billed) from a consultation service (when a consultation service is billed). Although Medicare has provided guidance, there has continued to be disagreement with our policy from AMA CPT staff and some members of the physician community. Because of the disparity between AMA coding guidance and Medicare policy, some physicians have stated that they have difficulty in choosing the appropriate code to bill. The payment for both inpatient consultation and office/outpatient consultation services is higher than for initial hospital care and new patient office/outpatient visits. However, the associated physician work is clinically similar. Many physicians contend that there is more work involved with a new patient visit than a consultation service because of the post work involvement with a new patient. The payment for a consultation service has been set higher than for initial visits because a written report must be made to the requesting professional. However, all medically necessary Medicare services require documentation in some form in a patient's medical record. Over the past several years, some physicians have asked CMS to recognize the provision of the consultation report via a different form of communication in lieu of a written letter report to the requesting physician so as to lessen any paperwork burden on physicians. We have eased the consultation reporting requirements by lessening the required level of formality and permitting the report to be made in any written form of communication, (including submission of a copy of the evaluation examination taken directly from the medical record and submitted without a letter format) as long as the identity of the physician who furnished the consultation is evident. Although preparation and submission of the consultant's report is no longer the major defining aspect of consultation services, the higher payment has remained. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.10 F.)

Both AMA CPT coding rules and Medicare Part B payment policy have always required that there is only one admitting physician of record for a particular patient in the hospital or nursing facility setting. (AMA CPT 2009, Hospital Inpatient Services, Initial Hospital Care, p.12) This physician has been the only one permitted to bill the initial hospital care codes or initial nursing facility codes. All other physicians must bill either the subsequent hospital care codes, subsequent nursing facility care codes or consultation codes. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.9.1 G.)

Beginning January 1, 2008, we ceased to recognize office/outpatient consultation CPT codes for payment of hospital outpatient visits (72 FR 66790 through 66795). Instead, we instructed hospitals to bill a new or established patient visit CPT code, as appropriate to the particular patient, for all hospital outpatient visits. Regardless of all of our efforts to educate physicians on Medicare guidance for documentation, transfer of care, and consultation policy, disagreement in the physician community prevails.

b. Summary of CY 2010 Proposal

In the CY 2010 PFS proposed rule (74 FR 33551), we proposed, beginning January 1, 2010, to budget neutrally eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G-codes) by increasing the work RVUs for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into our PE and malpractice RVU calculations.

We noted that section 1834(m) of the Act includes ''professional consultations'' (including the initial inpatient consultation codes ''as subsequently modified by the Secretary'') in the definition of telehealth services. We recognize that consultations furnished via telehealth can facilitate the provision of certain services and/or medical expertise that might not otherwise be available to a patient located at an originating site. Therefore, for CY 2010, we proposed to create HCPCS codes specific to the telehealth delivery of initial inpatient consultations. The purpose of these codes would be solely to preserve the ability for practitioners to provide and bill for initial inpatient consultations delivered via telehealth. These codes are intended for use by practitioners when furnishing services that meet Medicare requirements relating to coverage and payment for telehealth services. Practitioners would use these codes to submit claims to their Medicare contractors for payment of initial inpatient consultations provided via

telehealth. The proposed HCPCS codes would be limited to the range of services included in the scope of the CPT codes for initial inpatient consultations, and the descriptions would be modified to limit the use of such services for telehealth. The HCPCS codes would clearly designate these as initial inpatient consultations provided via telehealth, and not initial hospital care or initial nursing facility care used for inpatient visits. Utilization of these codes would allow us to provide payment for these services, as well as enable us to monitor whether the codes are used appropriately.

We also stated that, if we create HCPCS G-codes specific to the telehealth delivery of initial inpatient consultations, then we would crosswalk the RVUs for these services from the RVUs for initial hospital care (as described by CPT codes 99221 through 99223). We believed this is appropriate because a physician or practitioner furnishing a telehealth service is paid an amount equal to the amount that would have been paid if the service had been furnished without the use of a telecommunication system. Since physicians and practitioners furnishing initial inpatient consultations in a face-to-face encounter to hospital inpatients must continue to utilize initial hospital care codes (as described by CPT codes 99221 through 99223), we believe it is appropriate to set the RVUs for the proposed inpatient telehealth consultation G-codes at the same level as for the initial hospital care codes.

We considered creating separate G-codes to enable practitioners to bill initial inpatient telehealth consultations when furnished to residents of SNFs and crosswalking the RVUs to initial nursing facility care (as described by CPT codes 99304 through 99306). For the sake of administrative simplicity, if we create HCPCS G-codes specific to the telehealth delivery of initial inpatient consultations, they will be defined in § 410.78 and in our manuals as appropriate for use to deliver care to beneficiaries in hospitals or skilled nursing facilities.

We stated in the CY 2010 PFS proposed rule that if we adopt this proposal, we would then make corresponding changes to our regulations at § 410.78 and § 414.65. In addition, we would add the definition of these codes to the CMS Internet-Only Medicare Benefit Policy Manual, Pub. 100–02, Chapter 15, Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.

Outside the context of telehealth services, physicians will bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported. The initial visit in a skilled nursing facility and nursing facility must be furnished by a physician except as otherwise permitted as specified in § 483.40(c)(4). In the nursing facility setting, an NPP who is enrolled in the Medicare program, and who is not employed by the facility, may perform the initial visit when the State law permits this. (See this exception in the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.13 A). An NPP, who is enrolled in the Medicare program, is permitted to report the initial hospital care visit or new patient office visit, as appropriate, under current Medicare policy.

Because of an existing CPT coding rule and current Medicare payment policy regarding the admitting physician, we will create a modifier to identify the admitting physician of record for hospital inpatient and nursing facility admissions. For operational purposes, this modifier will distinguish the admitting physician of record who oversees the patient's care from other physicians who may be furnishing specialty care. The admitting physician of record will be required to append the specific modifier to the initial hospital care or initial nursing facility care code which will identify him or her as the admitting physician of record who is overseeing the patient's care. Subsequent care visits by all physicians and qualified NPPs will be reported as subsequent hospital care codes and subsequent nursing facility care codes.

We believe that the rationale for a differential payment for a consultation service is no longer supported because documentation requirements are now similar across all E/M services. To be consistent with OPPS policy, as noted above, we will pay only new and established office or other clinic visits under the PFS.

We proposed that this change would be implemented in a budget neutral manner, meaning it would not increase or decrease PFS expenditures. We proposed to make this change budget neutral for the work RVUs by increasing the work RVUs for new and established office visits by approximately 6 percent to reflect the elimination of the office consultation codes and the work RVUs for initial hospital and facility visits by approximately 2 percent to reflect the elimination of the facility consultation codes. We crosswalked the utilization for the office consultation codes into the office visits and the utilization of the hospital and facility consultation codes into the initial hospital and facility visits. We proposed that this change would be made budget neutral in the PE and malpractice RVU methodologies through the use of the new work RVUs and the crosswalked utilization.

We solicited comments on the proposal to eliminate payment for all consultation services codes under the PFS and to allow all physicians to bill, in lieu of a consultation service code, an initial hospital care visit or initial nursing facility care visit for their first visit during a patient's admission to the hospital or nursing facility. Additionally, we solicited comments on the proposal to create HCPCS G-codes to identify the telehealth delivery of initial inpatient consultations.

We received many comments on our proposal. MedPAC also commented on our proposal. The following is a summary of the comments we received regarding the discussion of the proposed changes to consultation services and our responses.

Comment: One commenter noted that ''there may be both advantages and disadvantages to this proposal,'' but urged that we refrain from finalizing it for January 1, 2010. The commenter expressed concerns about whether there would be sufficient time to educate physicians who currently employ the consultation codes in order to avoid ''a flood of claim denials and appeals.'' Other commenters raised similar concerns about whether there would be adequate time to educate physicians and billing personnel about the change and to assess the effects of the proposal.

Response: We agree that adoption of this proposal would call for appropriate measures to educate physicians and billing personnel about the change. However, we do not believe that the requisite educational efforts are extensive and complex enough as to warrant delaying implementation of the proposal. Essentially, the proposal would require physicians to cease submitting the consultation codes on their Medicare claims, and to employ the appropriate visit codes in their place. The determination of the appropriate visit code would be made solely on the basis of the existing rules and guidelines for the use of these codes, without any reference to the guidelines that have been employed for the use of the consultation codes. The guidelines for use of the visit codes are well established and well known and used by nearly all physicians. It is not necessary to develop any complicated coding crosswalk or guidelines for translating the consultation code

requirements for purposes of applying the visit codes. The major effects of the provision may actually simplify coding because physicians will use the office and hospital visit codes in place of consultations and will not have to determine whether the requirements to bill a consult are met. For these reasons, we believe the proposal should be implemented beginning January 1, 2010.

Comment: Some commenters urged delay or deferral of the proposal in order to allow time to determine whether the new CPT definition of ''transfer of care'' that goes into effect for 2010 would address concerns about the use of consultation codes. Other commenters stated more generally that the proposed change is not the appropriate way to resolve the confusion about using consultation codes versus patient visits.

Response: As we discussed in presenting our proposal, the confusion and disagreement about the proper use of the consultation codes have persisted for a long time. We discussed in detail our efforts over a period of years to clarify the guidelines and to resolve the persistent disagreements. As a result of this experience, we are skeptical that any further changes in guidelines or definitions would resolve these issues. We appreciate the efforts by the CPT committee to develop a new definition of transfer of care. However, we do not believe that this new definition will clarify all the ambiguities and resolve all the differences about the appropriate use of these codes.

As we stated when we implemented the PFS in 1992, one of our goals for the development of new visit and consultation codes was that they should be used reliably and consistently by all physicians and carriers, that is, that the same service should be coded the same way by different physicians. In addition, as we discussed in the CY 2010 PFS proposed rule, we believe that the confusion and disagreement about the use of the consultation codes have produced a situation in which that goal is far from being met.

As we also discussed in the proposed rule, we believe that a good deal of this confusion and disagreement arises from the use of terms such as referral, transfer, and consultation which are used sometimes interchangeably and sometimes inconsistently, by physicians in clinical settings.

The divergent interpretations and uses of these terms have served to confuse the meaning of a consultation service, as some label a transfer as a referral while others label a consultation as a referral. Even with the new definition of ''transfer of care,'' we foresee many clinical situations in which two physicians may not agree as to whether the referral was for consultation or transfer of care, and it may be difficult to resolve the issue based upon the conflicting interpretations reflected in the two physicians' medical records.

Comment: A number of commenters recommended a delay in order to develop alternative approaches on this issue. The commenters recommended that we revise the consultation codes or provide additional payments to physicians who provide thorough consultation reports to referring physicians.

Response: As we discussed in the proposed rule, we have considered numerous approaches to the issues posed by the use of the consultation codes over a period of years, and we have adopted some measures in an attempt to resolve those issues. We believe that, if there any other realistic and reasonable resolution to the issues surrounding the consultation codes, it would have emerged by now during the discussions that we have recounted above. The specific proposal mentioned by the commenter would have us pay more to physicians that provide thorough consultation reports to the referring physicians. However, we previously have tried to resolve the issues surrounding consultations in part by revising the documentation requirements, with the result that the documentation requirements for consultation codes have been reduced to the point where there is no longer a sufficient difference between the requirements for consultations and those for visits to justify a payment differential. The commenter's idea would have us return to increasing documentation requirements to receive higher payment for providing a thorough consultation report. We believe that any attempt to increase documentation requirements again to justify a payment differential will lead to objections from some physicians, and that it would be very difficult or impossible to define the requirements for a ''detailed report'' with sufficient precision to justify the provision of an additional payment.

Comment: Other commenters disagreed with our assessment that there is no substantial difference in work between consultations and visits. The commenters observed that consultations necessarily involve more complex cases that the referring physician is unable to treat. Furthermore, the commenters stated that these services require greater cognitive work and more complex medical decision making. Several commenters emphasized that consultation services required greater knowledge and expertise, acquired through additional training and experience, than is required for initial hospital and office visits. The preparation of a written report to the referring physician also requires additional time, regardless of the format in which the report is provided. One commenter expressed disagreement with our statement that ''the higher work value for consultations is entirely related to the provision of a written report to the requesting physicians.'' However, other commenters agreed with our assessment that there is no substantial difference in work between consultations and visits.

Response: To some degree, greater complexity and cognitive effort may be relative to the training and specialization of the physician. A case that presents clinical complexity and complex medical decision-making for one physician may be relatively simple and straightforward to another physician because of their repeated experience evaluating the same or similar problems. Evaluation and management services, although similar in the types of activities that occur during the encounter, may vary widely in the types of conditions being evaluated. The major difference between the work of a hospital or office visit and a consultation is that the patient has been referred to the consultant to obtain a specialized opinion. However, with the requirements lessened upon the consultant, the actual work done during the encounter with a patient for a consultation or an office or hospital visit has become harder to distinguish in terms of clinical complexity and medical decisionmaking. Further, many physicians contend that a new patient office visit may actually require more work than a consultation service because of the post work involvement with a new patient. As we discussed in the proposed rule, the documentation requirements for consultation services have been reduced to the point where it is difficult to justify a payment differential between consultations and new visits. Therefore, for these reasons, we support the view of those commenters who contend that in most cases, there is no substantial difference in work between consultations and visits.

Comment: Several commenters objected to the proposal on the grounds that it constitutes an unprecedented elimination of a set of CPT codes widely used by large numbers of physicians. Some commenters also stated that the proposal circumvents the CPT and AMA RUC processes.

Response: We do not agree that discontinuing the use of these codes for Medicare purposes is unprecedented. On the contrary, our proposal follows existing program precedent. As we noted in the proposed rule, beginning January 1, 2008, we ceased to recognize office/outpatient consultation CPT codes for payment of hospital outpatient visits (72 FR 66790 through 66795). Instead, we instructed hospitals to bill a new or established patient visit CPT code, as appropriate to the particular patient, for all hospital outpatient visits. We also do not believe that we have in any way circumvented the existing CPT and AMA RUC processes. We described in the CY 2010 PFS proposed rule the numerous attempts that we have made to resolve the relevant issues with AMA CPT staff. Despite all of our efforts to devise and implement relevant guidance, and educate physicians regarding documentation, transfer of care, and consultation policy, there is still substantial disagreement and inconsistency within the physician community regarding these issues.

Comment: Some commenters stated that the overall payment decreases that various specialists would face as a result of the proposed change are unwarranted.

Response: In making the proposal to eliminate use of the consultation codes under the PFS, it has not been our intention to increase or to decrease overall payments for any group or groups of physicians. Rather, our intent has been to provide for correct and consistent coding for services provided by physicians, as well as to provide for appropriate payment for the specific services that have been billed using the consultation codes, specifically, as well as the evaluation and management codes. It is in the nature of any budget neutral payment system for changes such as this to have a somewhat differential impact on various groups of providers and/or practitioners. In this particular case, we do not believe that these impacts are disproportionate to the goals we have sought to achieve in making and finalizing this proposal. It is important to keep in mind that, while elimination of the differential payment for consultation services will have a greater negative impact on some physician specialties than on others, all physicians will benefit from the budget neutral increase in the payment levels for the visit codes.

For more information on the impact of the changes in this rule, see section XIII. of this final rule with comment period.

Comment: Some commenters objected to our failure to increase the bundled payments for post-operative visits occurring over a 10-day or 90-day global period. For example, one major specialty society recommended extending the incremental work RVU increase to the E/M codes that are built into the 10-day and 90-day global codes. ''Arbitrarily changing the work RVUs for some E/M codes without adjusting the E/M components of other procedural codes undermines the relative value scale on which physician payment is based.'' The commenters otherwise supported the proposal, but strongly recommended that the global codes be increased for the sake of consistency. However, some other commenters who supported the proposal urged us to maintain this position in the final rule on the grounds that these services, by their very nature, were never billed as consultations.

Response: Payment for major surgeries includes bundled payment for the related post-operative visits occurring over a 10-day or 90-day global period. Historically, when payments for new and established office visits were increased after the third Five-Year Review, we also increased the bundled payments for these post-operative visits in the global period. However, we did not propose to increase the payments for the major surgeries to reflect the increase in the visits. We agree with those commenters who contended that consistency requires that we increase the bundled payments for these services proportionately in order to account for the increase in the visits that are incorporated into these bundles. We have accordingly increased the payments for those services in conjunction with finalizing our proposal to eliminate use of the consultation codes in the PFS. However, the increases in the payments for these services due specifically to this change are quite small because visits are a relatively small proportion of the total global payment amount.

Comment: A few commenters objected that we did not make available the crosswalk we used to relate the consultation codes to visit codes for purposes of ensuring BN. Other commenters expressed concerns about the assumptions we used in crosswalking the consultation codes to existing E/M codes. For example, one commenter stated that, for E/M services, a physician must consider three elements (extent of history obtained, extent of examination performed, and complexity of medical decision making) in determining the appropriate code level. However, for subsequent hospital care or hospital outpatient E/M services, only two of these three elements are necessary. In contrast, all three elements must be considered in determining the appropriate coding level for consultation services, both initial and follow-up consultations. There is no established patient visit code or subsequent hospital care code that adequately describes the work of consultation codes (CPT codes 99245 and 99255) when a patient is seen for follow-up consultation. One of these commenters noted that while there are five consultation codes, there are only three initial visit codes, and expressed concern that it would be difficult for physicians to accurately employ the visit codes for the services previously billed under the consultation codes. Another commenter observed that none of the E/M codes reflect the face-to-face times reflected in the highest level consultation codes (for example, 80 minutes for CPT code 99245 and 110 minutes for CPT code 99255). Still other commenters took issue with some elements of the destination mapping in our crosswalk, for example, the assumption that 50 percent of the cases represented as office consultation code (CPT code 99245) would be coded as a new patient office visit code (CPT code 99205), and 50 percent as an established patient office visit code (CPT code 99215).

Response: We made the relevant crosswalk available on our Web site at *http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=descending&itemID=CMS1223902&intNumPerPage=10*.

As we have noted above, we did not develop that crosswalk for purposes of providing any guidelines or principles for using the visit codes in place of the consultation codes that physicians have employed prior to the implementation of this proposal. Rather, the crosswalk was developed solely for purposes of making the requisite BN calculations. For purposes of coding specific cases, adoption of this proposal will essentially require physicians to cease submitting the consultation codes on their Medicare claims, and to employ the appropriate visit codes in their place. The determination of the appropriate visit code should be made solely on the basis of the existing rules and guidelines for the use of the relevant visit codes (for example, office visit or inpatient visit), without any reference to the guidelines that have been employed for the use of the consultation codes. The guidelines for use of the visit codes are well established and well understood. Therefore, we do not believe that it is necessary to provide any coding

crosswalk or guidelines for translating the consultation code requirements into the appropriate visit codes. Commenters are correct that while there are five consultation codes, there are only three initial visit codes, that none of the E/M codes reflect the face-to-face times reflected in the highest level consultation codes, and various other differences between the two sets of codes. Nevertheless, it remains possible to determine the appropriate visit code for the services in question by applying the appropriate guidelines and requirements for using those codes. There are, for example, legitimate coding measures to take into account face-to-face times over and above the times specified in the relevant visit codes. Since we ordinarily refrain from providing coding advice in this context, we recommend that physicians, coders, and billing personnel consult the appropriate manuals and coding authorities about how to make the appropriate coding determinations for services previously coded under the consultation codes.

In crosswalking the codes for purposes of making the requisite BN calculations, we employed the same estimating techniques that we normally employ in such calculations. In the absence of concrete data on certain factors in the calculation, we also employed standard assumptions that are appropriate in a system based on averages. For example, office consultation CPT code 99245 was employed to report consultations provided to new *or* established patients in a physician's office or other ambulatory setting. For purposes of making the BN calculations, it was necessary to apportion the utilization of that code between the separate office visit codes for new patients (CPT code 99205) and established patients (CPT code 99215). In the absence of concrete data on the number of new and established patients reported under CPT 99245, we employed the standard technique of assuming that half the patients were new patients, and half the patients were established patients. Such an assumption minimizes the range of potential error and negative impacts in a system based of averages. Similarly, with respect to the new or established patient initial inpatient consultation codes such as CPT code 99251, it was necessary to apportion the utilization estimates between inpatient visits in a hospital setting and in nursing homes. In this case, we believe that there would be far fewer consultation visits in nursing homes than in the inpatient hospital setting. Therefore, we adopted a standard assumption that 70 percent of the cases would be in inpatient hospitals (CPT initial hospital inpatient visit code 99221) and 30 percent in nursing homes (CPT initial nursing care facility visit code 99304). We employed similar assumptions throughout the crosswalk.

Comment: Several commenters maintained that we had not adequately responded to the OIG report about the use of consultation codes prior to developing this proposal. These commenters noted that the majority of the billing errors detected by the OIG were created by lack of documentation and/or services that did not meet the definition of consultation, and that the OIG recommended education and outreach to physicians to reduce such errors. The commenters recommended that we not proceed with the proposal until we can demonstrate that education and outreach efforts cannot improve the situation.

Response: Prior to the official publication of the OIG report, we issued a Medlearn Matters article, effective January 2006, to educate the physician community about requirements and proper billing for all types and levels of consultation services as requested by the OIG in their report. The Medlearn Matters article reflected the manual changes we made in 2006 and the AMA CPT coding changes as noted below. We have also answered numerous questions and inquiries regarding the use of these codes at open door forums and other settings.

With each additional revision from 1999 until the OIG study began, we made repeated efforts to educate physicians through the guidance provided by, and through, our Medicare contractors. However, there were continued discrepancies with unclear and ambiguous terms and instructions in the AMA CPT consultation coding definition, transfer of care and documentation, and the feedback from the physician community indicated they disagreed with Medicare guidance. Despite our best, these disagreements and misunderstandings among the physician community with Medicare interpretations and guidance relating to documentation of transfer of care and consultation have continued.

Comment: A number of commenters expressed concern about the effects of this proposal on coordination of payment between CMS and other payers. The commenters believe that if other payers continue to recognize consultation codes, the result could be confusion, erroneous billings, and serious delays or even denials of payment.

Response: We do not have the authority to determine which services will be recognized and paid by other third party payers. Some payers may choose to adopt this policy subsequent to this final rule. In cases where other payers do not adopt this policy, physicians and their billing personnel will need to take into consideration that Medicare will no longer recognize consultation codes submitted on bills, whether those bills are for primary or secondary payment. In those cases where Medicare is the primary payer, physicians must submit claims with the appropriate visit code in order to receive payment from Medicare for these services. In these cases, physicians should consult with the secondary payers in order to determine how to bill those services in order to receive secondary payment. In those cases where Medicare is the secondary payer, physicians and billing personnel will first need to determine whether the primary payer continues to recognize the consultation codes. If the primary payer does continue to recognize those codes, the physician will need to decide whether to bill the primary payer using visit codes, which will preserve the possibility of receiving a secondary Medicare payment, or to bill the primary payer with the consultation codes, which will result in a denial of payment for invalid codes.

Comment: One commenter stated that we had not responded to several letters over the last few years requesting clarification of the confusion over consultation and transfer of care, and providing suggested language to clarify the confusion. In addition, the commenter stated that the agency has never responded to a request that the contractors suspend audits of consultation services pending resolution of the confusion.

Response: We have received many similar requests and suggestions regarding the confusion over consultation and transfer of care over many years. We have continuously discussed these issues in the appropriate forums, including proposed and final rules, manual instructions, Medlearn matters articles, and meetings of the AMA CPT Committee. We recounted this extensive history in the proposed rule. As for the status of audits of consultation services, we generally do not discuss the specific audit measures and priorities that we are currently pursuing. In general, the goal of medical review is to identify, through analysis of data and evaluation of other information, program vulnerabilities concerning coverage and coding made by individual providers and to take the

necessary action to prevent or address the identified vulnerabilities.

Comment: A few commenters stated that it was inconsistent to continue separate payment for consultation services under the telehealth benefit, but to discontinue them in other contexts in which physician services are provided. Some commenters also stated that discontinuing the consultation codes may be contrary to the statute. Specifically, section 1845(c)(5) of the Act, states:

> Coding.—The Secretary shall establish a uniform coding system for the coding of all physician services. The Secretary shall provide for an appropriate coding structure for visits and consultations. The Secretary may incorporate the use of time in the coding for visits and consultations. The Secretary, in establishing such coding system, shall consult with the Physician Payment Review Commission and other organizations representing physicians.

Response: We note that section 1845(c)(5) of the Act calls for the Secretary to provide for ''an appropriate coding structure for visits and consultations.'' We believe the use of the adjective ''appropriate'' indicates that the statute is granting the Secretary discretion to determine the structure of coding for these services. For the reasons given above and in our proposed rule, we believe that we are creating an appropriate coding structure for visits and consultations by employing a set of codes that accurately describes, and permits appropriate payment for, those services. We also note that discontinuing the use of the consultation codes does not imply discontinuing payment for consultation services, but only discontinuing the payment differential between consultations and visits. These services will continue to be reported, coded, and paid under the PFS. On the other hand, as we noted previously, section 1834(m) of the Act merely states that the definition of telehealth services includes ''professional consultations,'' and points to the initial inpatient consultation codes (''as subsequently modified by the Secretary'') as part of the coding structure for such services. We believe it is more consistent with legislative intent, as expressed in this provision, to retain the separate recognition of consultation services in the context of telehealth services. We believe that we have appropriately exercised the Secretary's discretion under section 1845(c)(5) of the Act in eliminating the consultation codes under the PFS, while at the same time respecting the legislative intent underlying section 1834(m) of the Act for separate recognition of consultation services in the context of telehealth.

Comment: MedPAC commented that the proposed change ''seems an appropriate policy response'' to the relaxation of documentation requirements. However, the Commission noted that:

> * * * reduced consultation documentation may not sufficiently meet the needs of the requesting physician, and thus not help achieve the goals and benefits of well-coordinated care. While CMS' proposed payment policy for consultation may be appropriate in the light of current practice, in the future, the agency may wish to consider whether to increase the requirements for consultations in order to better coordinate care and increase consultation payments commensurately.

Other commenters expressed similar concerns that the elimination of the consultation codes might financially discourage coordination of care and communication among physicians.

Response: We appreciate MedPAC's evaluation that our proposal has merit as a response to the reduction in the documentation requirements for consultation services. We also agree with MedPAC that promoting effective coordination of care must be an essential goal of our payment systems. However, we are not aware of any evidence that the reduced consultation documentation requirements are currently failing to sufficiently meet the needs of referring physicians, or that the benefits of effective coordination of care are otherwise not being realized as result of these reduced requirements. If we become aware of such evidence in the future, we would certainly consider whether there is an appropriate policy response to promote more effective coordination of care. It is, however, premature to consider what the appropriate responses might be until and unless specific evidence of an issue comes to our attention. Nevertheless, we will certainly be attentive to any concerns that develop about the effects of this policy on the goal of promoting effective coordination of care.

Comment: Many other commenters supported the proposal. The commenters agreed with us that the documentation requirements are now generally similar among consultation services, office visits, and hospital and facility visits. The commenters also agreed that the proposed change would simplify documentation and resolve the confusion surrounding the billing of consultation codes, ''transfer of care,'' and other matters.

Response: We appreciate the support of the commenters, and we continue to believe that the approach we proposed is the most appropriate policy response to the confusion, disagreement, and problems that have beset the use of the consultation codes under the PFS. Accordingly, we are adopting our proposal in this final rule.

Specifically, beginning January 1, 2010, we will eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G-codes) on a budget neutral basis by increasing the work RVUs for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into our PE and malpractice RVU calculations.

Since section 1834(m) of the Act includes ''professional consultations'' (including the initial inpatient consultation codes ''as subsequently modified by the Secretary'') in the definition of telehealth services, we will not eliminate the use of these codes in the telehealth context. Therefore, for CY 2010, we will create HCPCS codes specific to the telehealth delivery of initial inpatient consultations. Specifically, we are establishing the following HCPCS codes to describe initial inpatient consultations approved for telehealth:

- G0425, *Initial inpatient telehealth consultation, typically 30 minutes communicating with the patient via telehealth.*
- G0426, *Initial inpatient telehealth consultation, typically 50 minutes communicating with the patient via telehealth.*
- G0427, *Initial inpatient telehealth consultation, typically 70 minutes or more communicating with the patient via telehealth.*

The purpose of these codes is solely to preserve the ability for practitioners to provide and bill for initial inpatient consultations delivered via telehealth. These codes are intended for use by practitioners when furnishing services that meet Medicare requirements relating to coverage and payment for telehealth services. Practitioners will use these codes to submit claims to their Medicare contractors for payment of initial inpatient consultations provided via telehealth. The new HCPCS codes will be limited to the range of services included in the scope of the CPT codes for initial inpatient consultations, and the descriptions will limit the use of such services for telehealth. Utilization of these codes will allow us to provide payment for these services, as well as enable us to monitor whether the codes are used appropriately.

As we also stated in the CY 2010 PFS proposed rule, we will crosswalk the RVUs for these services from the RVUs for initial hospital care (as described by CPT codes 99221 through 99223). We believed this is appropriate because a physician or practitioner furnishing a telehealth service is paid an amount equal to the amount that would have been paid if the service had been furnished without the use of a telecommunication system. Since physicians and practitioners furnishing initial inpatient consultations in a face-to-face encounter to hospital inpatients must continue to utilize initial hospital care codes (as described by CPT codes 99221 through 99223), we believe it is appropriate to set the RVUs for the proposed inpatient telehealth consultation G-codes at the same level as for the initial hospital care codes. As we stated in the CY 2010 PFS proposed rule, we also will make corresponding changes to our regulations at § 410.78 and § 414.65. In addition, we will add the definition of these codes to the CMS Internet-Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.

Outside the context of telehealth services, physicians will bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported. The initial visit in a skilled nursing facility and nursing facility must be furnished by a physician except as otherwise permitted as specified in § 483.40(c)(4). In the nursing facility setting, an NPP who is enrolled in the Medicare program, and who is not employed by the facility, may perform the initial visit when the State law permits this. (See this exception in the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.13 A). An NPP, who is enrolled in the Medicare program is permitted to report the initial hospital care visit or new patient office visit, as appropriate, under current Medicare policy. Because of an existing CPT coding rule and current Medicare payment policy regarding the admitting physician, we will create a modifier to identify the admitting physician of record for hospital inpatient and nursing facility admissions. For operational purposes, this modifier will distinguish the admitting physician of record who oversees the patient's care from other physicians who may be furnishing specialty care. The admitting physician of record will be required to append the specific modifier to the initial hospital care or initial nursing facility care code which will identify him or her as the admitting physician of record who is overseeing the patient's care. Subsequent care visits by all physicians and qualified NPPs will be reported as subsequent hospital care codes and subsequent nursing facility care codes.

As proposed, this change will be implemented in a budget neutral manner, meaning that it will not increase or decrease aggregate PFS expenditures. We will make this change budget neutral for the work RVUs by increasing the work RVUs for new and established office visits by approximately 6 percent to reflect the elimination of the office consultation codes and the work RVUs for initial hospital and facility visits by approximately 0.3 percent to reflect the elimination of the facility consultation codes. As discussed above, in this final rule we are also increasing the incremental work RVUs for the E/M codes that are built into the 10-day and 90-day global surgical codes. As we did for the CY 2010 PFS proposed rule, we have crosswalked the utilization for the office consultation codes into the office visits and the utilization of the hospital and facility consultation codes into the initial hospital and facility visits. And, as we proposed, this change will be made budget neutral in the PE and malpractice RVU methodologies through the use of the new work RVUs and the crosswalked utilization.

F. Potentially Misvalued Services Under the Physician Fee Schedule

1. Valuing Services Under the Physician Fee Schedule

As explained in the CY 2010 PFS proposed rule (74 FR 33554), the American Medical Association's (AMA) Relative Value System Update Committee (RUC) provides recommendations to CMS for the valuation of new and revised codes, as well as codes identified as misvalued. On an ongoing basis, the AMA RUC's Practice Expense (PE) Subcommittee reviews direct PE (clinical staff, medical supplies, medical equipment) for individual services and examines the many broad and methodological issues relating to the development of PE relative value units (RVUs).

To address concerns expressed by stakeholders with regard to the process we use to price services paid under the PFS, the AMA RUC created the Five-Year Review Identification Workgroup. As we stated in the CY 2009 PFS proposed rule (73 FR 38582), the workgroup identified some potentially misvalued codes through several vehicles. It focused on codes for which there have been shifts in the site of service (site of service anomalies), codes with a high intra-service work per unit of time (IWPUT), high volume codes, new technology designation, and shifts from practice expense to work. We also identified other methods that the AMA RUC could undertake to assist in identifying potentially misvalued services including reviewing the fastest growing procedures, Harvard-valued codes, and practice expense RVUs. There were 204 potentially misvalued services identified in 2008.

We believe that there are additional steps we can take to address the issue of potentially misvalued services. In the CY 2009 PFS proposed rule, we identified approaches to address this issue including reviewing services often billed together and the possibility of expanding the multiple procedure payment reduction (MPPR) to additional nonsurgical procedures and the update of high cost supplies.

Comment: We received several comments concerning the misvalued code initiative. One commenter, representing a physician specialty organization, expressed concern about the ongoing misuse of intraservice work per unit of time (IWPUT) as a means to determine appropriate work values. The commenter states that IWPUT was never intended to compare intensity or work across specialties and was to be used only as a measure of relativity between codes or in families of codes. Commenters also expressed concern about the need for transparency concerning the development of values for codes, including the review of PE inputs; the need for CMS to consider the underlying reasons why utilization for certain services may increase; and the economic and public health implications of appropriate valuation of services. A commenter also recommended that the agency become more proactive in identifying problematic trends in utilization and in re-evaluating new technology. The commenter recognized that additional resources would be needed and acknowledged that the Congress may need to ensure adequate resources are available but believes that such an investment could result in lower overall costs in the system over the long-term.

Response: We thank the commenters for sharing their concerns and will consider them as we continue examining the valuation of services under the misvalued code initiative.

We also share some the concerns expressed by the commenter with regards to IWPUT, which is a

calculation that was used as the primary tool to value physician services for some codes during the third Five-Year Review. This calculation poorly assesses intensity for services that are short in time duration and also services that are short in time duration and of high intensity. The IWPUT has also been used to align procedures within a family of codes. It has value in some instances, such as in validating the RVUs for a given procedure using the building block methodology. However, the IWPUT has not proven to be a valuable tool in evaluating or validating cognitive services. The building block methodology is the accepted methodology used by the AMA RUC and CMS for valuing all physician procedures and services. We believe that the building block methodology should be consistently used when the AMA RUC considers valuation of physician services for its recommendations.

2. High Cost Supplies

In the CY 2010 PFS proposed rule (74 33554), we referenced our CY 2009 PFS proposal concerning updating prices for high cost supplies (73 FR 38582) and (73 FR 69882), and stated that we are continuing to examine alternatives on the best way to obtain accurate pricing information and will propose a revised process in future rulemaking.

The following is a summary of the comments received to date regarding high cost supplies and our response.

Comment: Several commenters expressed support for this initiative. A few commenters were disappointed that we did not propose any new methodologies in the CY 2010 PFS proposed rule.

Commenters were in agreement that we must ensure accurate pricing of supplies, as the cost of supplies plays an important role in the payment calculation for services under the PFS.

Commenters also offered the following suggestions for pricing high cost supplies including:

- Identify high cost disposable supplies (that is, over $200) with separate HCPCS codes;
- Use the supply pricing methodology used by the Veterans Administration;
- Work with specialty societies to obtain invoices for high priced items from a designated group of physicians that are geographically representative; and
- Work with the industry or physicians directly to get current pricing information.

MedPAC stated it is important for us to update the prices of higher priced supplies on a regular basis as inaccurate prices can distort PE RVUs over time. MedPAC believes that prices drop over time as items diffuse through the market and as other companies begin to produce them, and encouraged us to regularly update information.

A few commenters also recommended that any pricing proposal should be available for public comment through future rulemaking, possibly on an annual basis. This would enable stakeholders to evaluate and provide feedback to the agency on pricing accuracy as well as practical availability of the item itself.

Response: We want to thank the commenters for sharing their suggestions and will take these comments into consideration as we explore the best way to address this issue.

3. Review of Services Often Billed Together and the Possibility of Expanding the Multiple Procedure Payment Reduction (MPPR) to Additional Nonsurgical Procedures

In the CY 2009 PFS final rule with comment period (73 FR 69882), we stated that we planned to perform a data analysis of nonsurgical CPT codes that are often billed together. We stated that we would identify whether there are inequities in PFS payments that are a result of variations between services in the comprehensiveness of the codes used to report the services or in the payment policies applied to each (for example, global surgery and MPPRs). The rationale for the MPPR is that certain clinical labor activities, supplies, and equipment are not performed or furnished twice when multiple procedures are performed. The MPPR currently applies to certain diagnostic and surgical procedures (73 FR 38586). We stated that we would consider developing a proposal either to bundle more services or expand application of the MPPR to additional procedures. Additionally, the Medicare Payment Advisory Committee (MedPAC) requested that we consider duplicative physician work and PE in any expansion of the MPPR.

In the CY 2010 PFS proposed rule (74 FR 33554), we stated that we planned to analyze codes furnished together more than 75 percent of the time, excluding E/M codes. We also stated that we planned to analyze both physician work and PE inputs. If duplications are found, we said that we would consider whether to propose to implement an MPPR or to bundle the services involved. We stated that we would propose any changes through future rulemaking.

Comment: Several commenters did not support the analysis of codes furnished together more than 75 percent of the time. The commenters stated that limiting the review to codes performed together 90 to 95 percent of the time was more appropriate. A few commenters suggested that 75 percent should not be the only criterion we use when considering whether to implement an MPPR or bundle services. Some commenters requested that we postpone our review of services that are often billed together and rely on the work that is being done in this area by the AMA RUC. The commenters believe that the work the AMA RUC is doing will be informative regarding which services should be considered in the future in determining whether to propose to expand the MPPR or to bundle services. The AMA RUC stated that it wants to work with CMS to accurately assess these services.

A few commenters generally supported the analysis of codes furnished together more than 75 percent of the time. One commenter stated that almost all imaging procedures and equipment have become more efficient in recent years allowing more procedures in a given time.

Most commenters were in agreement that this policy should not be expanded until CMS has additional data and there is an opportunity for public comment through future rulemaking.

Response: We appreciate the comments received and will consider these comments as we explore the best way to address this issue. We also look forward to working with the AMA RUC to accurately assess these services.

4. AMA RUC Review of Potentially Misvalued Codes

a. Site of Service

In the CY 2009 PFS final rule with comment period (73 FR 69883), we said that although we would accept the AMA RUC valuation for these site of service anomaly codes for 2009, we indicated that we had concerns about the methodology used by the AMA RUC to review these services because they may have resulted in removal of hospital days and deletion or reallocation of office visits without extraction of the associated RVUs from the valuation of the code. We also stated that we would continue to examine these codes and would consider whether it would be appropriate to propose additional changes in future rulemaking.

In the CY 2010 PFS proposed rule (74 FR 33554), we proposed work RVU changes to several of the codes where the valuation had been adjusted to

reflect changes in the site of service but the RVUs had not been extracted by the AMA RUC. The proposed work RVUs were recalculated based upon the AMA RUC-recommended inputs (that is, changes in pre-service and post-service times and associated E/M services). The proposed work RVUs for each CPT code were recalculated using the pre-AMA RUC review work RVUs as a starting point, and adjusted for the addition or extraction of pre-service and post-service times, inpatient hospital days, discharge day management services and outpatient visits as recommended by the AMA RUC.

In addition to the proposed revisions to the AMA RUC-recommended RVUs, we encouraged the AMA RUC to utilize the building block methodology as described in the CY 2007 PFS proposed rule (71 FR 37172) in the future when revaluing codes with site of service anomalies. We recognized that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. However, we stated that we believed that the relative value scale requires each service to be valued based on the resources used in furnishing the service.

We also sought public comment on alternative methodologies that could be used to establish work RVUs for codes that would have a negative valuation under the methodology we utilized to develop proposed revisions to the AMA RUC-recommended values described above.

The following is summary of the comments we received regarding the proposed revisions to the codes with site of service anomalies.

Comment: Some commenters supported CMS' attempt to account for recognized changes in physician work for certain procedures in which the typical site of service has changed. However, other commenters opposed the proposed work RVUs and found the methodology unclear and problematic since some cases resulted in negative work values. Many commenters recommended the acceptance of the AMA RUC recommended values and encouraged CMS to work with them to develop a clearer methodology.

Response: As a result of the comments, we are not finalizing our proposal to change the work RVUs for codes with site of service anomalies that were included in Table 8 of the CY 2010 proposed rule (74 FR 33555). Although we still have concerns about the methodology used by the AMA RUC to review the services, we are accepting the AMA RUC-recommended work RVUs in the interim and request that the AMA RUC utilize the building block methodology to revalue the services listed in Table 4.

TABLE 4—CY 2010 CMS INTERIM WORK RVUS FOR SITE OF SERVICE ANOMALIES REVIEWED BY THE AMA RUC IN CY 2009

CPT code [1]	Descriptor	2009 AMA RUC recommended work RVU	CMS decision	2010 CMS interim work RVU [2]
21025	Excision of bone, lower jaw	9.87	Agree	10.03
23415	Release of shoulder ligament	9.07	Agree	9.23
25116	Remove wrist/forearm lesion	7.38	Agree	7.56
42440	Excise submaxillary gland	7.05	Agree	7.13
52341	Cysto w/ureter stricture tx	5.35	Agree	5.35
52342	Cysto w/up stricture tx	5.85	Agree	5.85
52343	Cysto w/renal stricture tx	6.55	Agree	6.55
52344	Cysto/uretero, stricture tx	7.05	Agree	7.05
52345	Cysto/uretero w/up stricture	7.55	Agree	7.55
52346	Cystouretero w/renal strict	8.58	Agree	8.58
52400	Cystouretero w/congen repr	8.66	Agree	8.69
52500	Revision of bladder neck	7.99	Agree	8.14
52640	Relieve bladder contracture	4.73	Agree	4.79
53445	Insert uro/ves nck sphincter	15.21	Agree	15.39
54410	Remove/replace penis prosth	15.00	Agree	15.18
54530	Removal of testis	8.35	Agree	8.46
57287	Revise/remove sling repair	10.97	Agree	11.15
62263	Epidural lysis mult sessions	6.41	Agree	6.54
62350	Implant spinal canal cath	6.00	Agree	6.05
63650	Implant neuroelectrodes	7.15	Agree	7.20
63685	Insrt/redo spine n generator	6.00	Agree	6.05
64708	Revise arm/leg nerve	6.22	Agree	6.36
64831	Repair of digit nerve	9.00	Agree	9.16
65285	Repair of eye wound	14.43	Agree	14.71

[1] All CPT codes copyright 2009 American Medical Association.
[2] 2010 CMS Interim Work RVUs may differ from AMA RUC-recommended work RVU due to work increases in 10 and 90 day global codes as a result of the elimination of the consultation codes.

b. ''23-Hour'' Stay

Services that are performed in the hospital outpatient setting and require a stay of less than 24 hours are considered outpatient services. We received recommendations from the AMA RUC for inclusion of inpatient services for services that are typically performed in an outpatient setting.

In the 2010 PFS proposed rule (74 FR 33556), we stated that we believed the use of E/M codes for services rendered in the post-service period for procedures requiring less than a 24-hour hospital stay would result in overpayment for pre- and post-service work that would not be provided. Therefore, we stated that we would not allow an additional E/M service to be billed for care furnished during the post procedure period when care is furnished for an outpatient service requiring less than a 24-hour hospital stay.

The following is summary of the comments we received regarding the proposed revisions to the ''23-Hour'' stay.

Comment: The majority of commenters disagreed with CMS'

proposal because they believed it would result in surgeons not being paid for the work they perform. Commenters urged CMS to engage in a discussion at CPT and/or the AMA RUC regarding alternative E/M coding solutions.

Response: As a result of the comments, we are not finalizing our proposal and will work with CPT and the AMA RUC regarding alternative E/M coding solutions to address our concerns about using inpatient hospital visit codes as a proxy for the work being performed.

c. AMA RUC Review of Potentially Misvalued Codes for CY 2010

We are addressing the AMA RUC's recommendations from the February and April 2009 meetings for potentially misvalued codes in this final rule with comment period in a manner consistent with the way we address other AMA RUC recommendations. Specifically, we completed our own review of the AMA RUC recommendations and we describe the AMA RUC's recommendations, indicate whether or not we accept them, and provide a rationale for our decision in this final rule with comment period. The values for these services are interim values for the next calendar year.

The AMA RUC continued its review of potentially misvalued codes using various screens, including codes with site of anomalies, high IWPUT, high volume, fastest growing procedures, and other CMS requests. For CY 2010, the AMA RUC submitted recommendations for 113 codes. Of those codes 1 was recommended for a reduction in valuation; 7 were recommended for an increase in valuation; 11 were recommended to maintain the same valuation; 45 were referred to CPT for further code clarification, 33 were recommended for PE changes and 16 were recommended for clinical labor revisions.

We have agreed to accept the valuation for these codes for CY 2010 as interim, including the conforming changes to the PE inputs for these codes, as applicable with the exception of CPT 92597, *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech.* With the enactment of the MIPPA, speech-language pathologists were able to bill the Medicare program independently as private practitioners effective July 1, 2009. In response, speech-language pathologists requested that the AMA RUC value the work of certain codes. Previously, the work of the speech-language pathologists had been accounted for and paid under the PE component for these codes. CPT code 92597 was evaluated by the AMA RUC, after which the AMA RUC recommended a work RVU of 1.48 based upon a survey that included speech-language pathologists and otolaryngologists, the most frequent providers of the service. The work description for CPT code 92597 includes initial fitting of a prosthesis. The code descriptor for CPT code 31611, *Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis),* with a work RVU of 5.92 also includes insertion or fitting of a speech prosthesis. Otolaryngologists perform this service a majority of the time. It appears that both codes include fitting a prosthesis and that there is an overlap of work between CPT codes 92597 and 31611. To account for the overlap of work between these two codes, for CPT code 92597 we have assigned a work RVU value at the 25th percentile, 1.26 work RVUs. We note that the work RVU for CPT code 31611 may not have been reviewed by the RUC since 1995. We invite the RUC to review these two codes and any others for which work may overlap.

We continue to have concerns about the methodology used by the AMA RUC to review services with site of service anomalies. We request that the AMA RUC utilize the building block methodology to revalue these services.

The AMA RUC also recommended that we review claims data for CPT codes 76970, *Ultrasound study follow-up (specify),* 94450, *Breathing response to hypoxia (hypoxia response curve),* 94014, *Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation,* 94015, *Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)* and 94016, *Patient-initiated spirometric recording per 30-day period of time; physician review and interpretation only.* We will take the AMA RUC's suggestions under consideration and further investigate these claims.

5. PE Issues—Arthoscopy

Previously, the AMA RUC recommended that an arthoscopic procedure (CPT code 29870, *Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure*)) not be valued in the non-facility setting because they believed the procedure was unsafe to perform outside of the facility setting. In the CY 2008 PFS final rule (72 FR 66238), we deferred proposing non-facility inputs for these types of procedures. We stated that the physicians performing arthroscopic services in the non-facility setting should be given the opportunity to have a multi-specialty review by the AMA RUC.

Comment: We have received many inquiries about why CPT code 29870 was not valued in the non-facility setting. For CY 2010, in response to a request from CMS, the AMA RUC has recommended PE inputs for CPT code 29870.

Response: We accept the AMA RUC's recommended PE inputs for this procedure and are valuing this code in the non-facility setting.

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TABLE 5: CY 2010 CMS Interim Work RVUs for Potentially Misvalued Codes Reviewed by the AMA RUC in CY 2010

CPT Code[1]	Descriptor	RUC Rec	CMS Decision	2010 WRVU[2]	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
11040	DEBRIDE SKIN, PARTIAL	CPT	Agree	0.50	X							
11041	DEBRIDE SKIN, FULL	CPT	Agree	0.60	X							
11042	DEBRIDE SKIN/TISSUE	CPT	Agree	0.80	X							
13120	REPAIR OF WOUND OR LESION	CPT	Agree	3.35				X				
13121	REPAIR OF WOUND OR LESION	CPT	Agree	4.42				X				
13122	REPAIR WOUND/LESION ADD-ON	CPT	Agree	1.44				X				
19340	IMMEDIATE BREAST PROSTHESIS	13.78; Change in global period from ZZZ to 090	Agree	13.78								X
22520	PERCUT VERTEBROPLASTY THOR	New PE Inputs	Agree	a							X	
22521	PERCUT VERTEBROPLASTY LUMB	New PE Inputs	Agree	a	X						X	
22533	LAT LUMBAR SPINE FUSION	CPT	Agree	24.79				X				
22849	REINSERT SPINAL FIXATION	CPT	Agree	19.17				X				
26080	EXPLORE/TREAT FINGER JOINT	CPT	Agree	4.47	X							
26480	TRANSPLANT HAND TENDON	6.76	Agree	6.90				X				
27370	INJECTION FOR KNEE X-RAY	CPT	Agree	0.96			X	X				
28120	PART REMOVAL OF ANKLE/HEEL	8.08	Agree	8.27	X							
28122	PARTIAL REMOVAL OF FOOT BONE	7.56	Agree	7.72	X							
28725	FUSION OF FOOT BONES	11.97	Agree	12.18	X							
28730	FUSION OF FOOT BONES	12.21	Agree	12.42	X							

CPT Code[1]	Descriptor	RUC Rec	CMS Decision	2010 WRVU[2]	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
29870	KNEE ARTHROSCOPY, DX	New PE Inputs - Non-Facility Setting	Agree	(a)							X	
35471	REPAIR ARTERIAL BLOCKAGE	CPT	Agree	10.05				X				
35472	REPAIR ARTERIAL BLOCKAGE	CPT	Agree	6.90				X				
35473	REPAIR ARTERIAL BLOCKAGE	CPT	Agree	6.03				X				
35475	REPAIR ARTERIAL BLOCKAGE	CPT	Agree	9.48				X				
35476	REPAIR VENOUS BLOCKAGE	CPT	Agree	6.03				X				
36481	INSERTION OF CATHETER, VEIN	New PE Inputs	Agree	(a)							X	
36516	APHERESIS, SELECTIVE	CPT	Agree	1.22				X				
36825	ARTERY-VEIN AUTOGRAFT	15.00	Agree	15.13	X							
37183	REMOVE HEPATIC SHUNT (TIPS)	New PE Inputs	Agree	(a)							X	
42415	EXCISE PAROTID GLAND/LESION	17.99	Agree	18.12	X							
42420	EXCISE PAROTID GLAND/LESION	20.87	Agree	21.00	X							
47382	PERCUT ABLATE LIVER RF	New PE Inputs	Agree	(a)							X	
47490	INCISION OF GALLBLADDER	CPT and recommended 000 day global review	Agree	8.13				X				
49421	INSERT ABDOM DRAIN, PERM	CPT	Agree	5.90	X							
49507	PRP I/HERN INIT BLOCK >5 YR	9.97	Agree	10.05	X							
49521	REREPAIR ING HERNIA, BLOCKED	12.36	Agree	12.44	X							
49587	RPR UMBIL HERN, BLOCK > 5 YR	7.96	Agree	8.04	X							
50200	RENAL BIOPSY PERQ	New PE Inputs	Agree	(a)							X	

CPT Code[1]	Descriptor	RUC Rec	CMS Decision	2010 WRVU[2]	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
52214	CYSTOSCOPY AND TREATMENT	CPT	Agree	3.70			X					
52224	CYSTOSCOPY AND TREATMENT	CPT	Agree	3.14			X					
55873	CRYOABLATE PROSTATE	13.45 and Revised PE Inputs	Agree	13.60							X	
58555	HYSTEROSCOPY, DX, SEP PROC	New PE inputs	Agree	(a)							X	
58558	HYSTEROSCOPY, BIOPSY	New PE inputs	Agree	(a)							X	
58562	HYSTEROSCOPY, REMOVE FB	New PE inputs	Agree	(a)							X	
58563	HYSTEROSCOPY, ABLATION	New PE inputs	Agree	(a)							X	
61795	BRAIN SURGERY USING COMPUTER	CPT	Agree	4.03				X				
61885	INSRT/REDO NEUROSTIM 1 ARRAY	CPT	Agree	7.57	X							
63056	DECOMPRESS SPINAL CORD	CPT	Agree	21.86				X				
64510	N BLOCK, STELLATE GANGLION	New PE inputs	Agree	(a)								
64520	N BLOCK, LUMBAR/THORACIC	PE Review - no change	Agree	(a)								
64573	IMPLANT NEUROELECTRODES	CPT	Agree	8.25	X							
64622	DESTR PARAVERTEBRL NERVE L/S	PE Review - no change	Agree	(a)			X	X			X	
64626	DESTR PARAVERTEBRL NERVE C/T	PE Review - no change	Agree	(a)			X	X			X	
65780	OCULAR RECONST, TRANSPLANT	CPT	Agree	10.73				X				

CPT Code[1]	Descriptor	RUC Rec	CMS Decision	2010 WRVU[2]	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
66982	CATARACT SURGERY, COMPLEX	CPT	Agree	15.02	X	X		X				
69100	BIOPSY OF EXTERNAL EAR	0.81	Agree	0.81				X				
71275	CT ANGIOGRAPHY, CHEST	CPT	Agree	1.92				X				
73218	MRI UPPER EXTREMITY W/O DYE	CPT	Agree	1.35				X				
73580	CONTRAST X-RAY OF KNEE JOINT	CPT	Agree	0.54			X	X				
75885	VEIN X-RAY, LIVER	New PE inputs	Agree	(a)							X	
75887	VEIN X-RAY, LIVER	New PE inputs	Agree	(a)							X	
76100	X-RAY EXAM OF BODY SECTION	New PE inputs	Agree	(a)							X	
76101	COMPLEX BODY SECTION X-RAY	New PE inputs	Agree	(a)							X	
76102	COMPLEX BODY SECTION X-RAYS	New PE inputs	Agree	(a)							X	
76536	US EXAM OF HEAD AND NECK	0.56	Agree	0.56				X				
77301	RADIOTHERAPY DOSE PLAN, IMRT	CPT	Agree	7.99				X				
77371	SRS, MULTISOURCE	New PE inputs	Agree	(a)							X	
77418	RADIATION TX DELIVERY, IMRT	CPT	Agree	0.00				X				
77785	HDR BRACHYTX, 1 CHANNEL	New PE Inputs	Agree	(a)							X	
77786	HDR BRACHYTX, 2-12 CHANNEL	New PE Inputs	Agree	(a)							X	
77787	HDR BRACHYTX OVER 12 CHAN	New PE Inputs	Agree	(a)							X	
90951	ESRD SERV, 4 VISITS P MO, <2	Revised clinical staff time	Agree	(b)							X	

CPT Code[1]	Descriptor	RUC Rec	CMS Decision	2010 WRVU[2]	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
90952	ESRD SERV, 2-3 VSTS P MO, <2	Revised clinical staff time	Agree	(b)							X	
90953	ESRD SERV, 1 VISIT P MO, <2	Revised clinical staff time	Agree	(b)							X	
90954	ESRD SERV, 4 VSTS P MO, 2-11	Revised clinical staff time	Agree	(b)							X	
90955	ESRD SRV 2-3 VSTS P MO, 2-11	Revised clinical staff time	Agree	(b)							X	
90956	ESRD SRV, 1 VISIT P MO, 2-11	Revised clinical staff time	Agree	(b)							X	
90957	ESRD SRV, 4 VSTS P MO, 12-19	Revised clinical staff time	Agree	(b)							X	
90958	ESRD SRV 2-3 VSTS P MO 12-19	Revised clinical staff time	Agree	(b)							X	
90959	ESRD SERV, 1 VST P MO, 12-19	Revised clinical staff time	Agree	(b)							X	
90960	ESRD SRV, 4 VISITS P MO, 20+	Revised physician and clinical staff time	Agree	(b)							X	
90961	ESRD SRV, 2-3 VSTS P MO, 20+	Revised physician and clinical staff time	Agree	(b)							X	
90962	ESRD SERV, 1 VISIT P MO, 20+	Revised clinical staff time	Agree	(b)							X	

CPT Code[1]	Descriptor	RUC Rec	CMS Decision	2010 WRVU[2]	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
90963	ESRD HOME PT, SERV P MO, <2	Revised clinical staff time	Agree	(b)							X	
90964	ESRD HOME PT SERV P MO, 2-11	Revised clinical staff time	Agree	(b)							X	
90965	ESRD HOME PT SERV P MO 12-19	Revised clinical staff time	Agree	(b)							X	
90966	ESRD HOME PT, SERV P MO, 20+	Revised clinical staff time	Agree	(b)							X	
92526	ORAL FUNCTION THERAPY	1.34 work RVU and clinical staff time removed	Agree	1.34					X			
92587	EVOKED AUDITORY TEST	CPT	Agree	0.13				X				
92597	ORAL SPEECH DEVICE EVAL	1.48 work RVU and clinical staff time removed	Disagree	1.26					X			
92610	EVALUATE SWALLOWING FUNCTION	1.30 work RVU and clinical staff time removed	Agree	1.30					X			
92611	MOTION FLUOROSCOPY/SWALLOW	1.34 work RVU and clinical staff time removed	Agree	1.34					X			
93017	CARDIOVASCULAR STRESS TEST	PE Review - no change	Agree	(a)			X				X	
93230	ECG MONITOR/REPORT, 24 HRS	CPT	Agree	0.52								X
93233	ECG MONITOR/REVIEW, 24 HRS	CPT	Agree	0.52								X

CPT Code[1]	Descriptor	RUC Rec	CMS Decision	2010 WRVU[2]	Site of Service Screen	High IWPUT	RUC High Volume	CMS Fastest Growing	Shift from PE to Work	Codes Reported Together	CMS Request PE Review	CMS Request Final Rule
93307	TTE W/O DOPPLER, COMPLETE	New PE inputs	Agree	(a)							X	
93320	DOPPLER ECHO EXAM, HEART	New PE inputs	Agree	(a)							X	
93325	DOPPLER COLOR FLOW ADD-ON	New PE inputs	Agree	(a)							X	
93510	LEFT HEART CATHETERIZATION	CPT	Agree	4.32						X	X	
93543	INJECTION FOR HEART X-RAYS	CPT	Agree	0.29						X	X	
93545	INJECT FOR CORONARY X-RAYS	CPT	Agree	0.40						X	X	
93555	IMAGING, CARDIAC CATH	CPT	Agree	0.81						X	X	
93556	IMAGING, CARDIAC CATH	CPT	Agree	0.83						X	X	
93922	EXTREMITY STUDY	CPT	Agree	0.25				X				
93923	EXTREMITY STUDY	CPT	Agree	0.45				X				
93924	EXTREMITY STUDY	CPT	Agree	0.50				X				
94760	MEASURE BLOOD OXYGEN LEVEL	New PE inputs	Agree	(a)							X	
94761	MEASURE BLOOD OXYGEN LEVEL	New PE inputs	Agree	(a)							X	
94762	MEASURE BLOOD OXYGEN LEVEL	New PE inputs	Agree	(a)				X			X	
94770	EXHALED CARBON DIOXIDE TEST	Should be N/A for Non-Facility PE	Agree	(a)			X					
95803	ACTIGRAPHY TESTING	New PE inputs	Agree	(a)							X	
95922	AUTONOMIC NERV FUNCTION TEST	CPT	Agree	0.96			X	X				
95956	EEG MONITORING, CABLE/RADIO	CPT	Agree	3.08				X				
G0180	MD CERTIFICATION HHA PATIENT	CPT	Agree	0.67				X				

[1] CPT codes and descriptors only are copyright 2009 American Medical Association.
[2] Work RVUs recommended by CMS may differ from the AMA RUC recommended value due to work increases in 10 and 90 day global codes as a result of the elimination of the consultation codes.
(a) Work RVU unchanged; code was reviewed for PE only.
(b) Work RVU unchanged; code was reviewed for clinical staff time only.

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6. Establishing Appropriate Relative Values for Physician Fee Schedule Services

In MedPAC's March 2006 Report to Congress, MedPAC made a number of recommendations to improve the review of the relative values for PFS services. Since that time, we have taken significant actions to improve the accuracy of the RVUs. As MedPAC noted in its recent March 2009 Report to Congress, ''CMS and the AMA RUC have taken several steps to improve the review process'' in the intervening years since those initial recommendations. Many of our efforts to improve the accuracy of RVUs have also resulted in substantial increases in the payments for primary care services.

The original March 2006 recommendation was summarized in the March 2008 Report to Congress:

> We also recommended that CMS establish a group of experts, separate from the AMA RUC, to help the agency conduct these and other activities. This recommendation was intended not to supplant the AMA RUC but to augment it. To that end, the panel should include members who do not directly benefit from changes to Medicare's payment rates, such as experts in medical economics and technology diffusion and physicians who are employed by managed care organizations and academic medical centers.

The idea of a group of experts separate from the AMA RUC, to help the agency improve the review of relative values, raises a number of issues. In the proposed rule, we solicited input on specific points concerning the creation of such a group, including:

- How could input from a group of experts best be incorporated into existing processes of rulemaking and agency receipt of AMA RUC recommendations?
- What specifically would be the roles of a group of experts (for example, identify potentially misvalued services, provide recommendations on valuation of specified services, review AMA RUC recommendations selected by the Secretary, etc.)?
- What should be the composition of a group of experts? How could such a group provide expertise on services that clinician group members do not furnish?
- How would such a group relate to the AMA RUC and existing Secretarial advisory panels such as the Practicing Physician Advisory Committee?

We also requested comments on the resources required to establish and maintain such a group. We stated that we would consider these comments as we consider the establishment of a group of experts to assist us in our ongoing reviews of the PFS RVUs.

Comments: We received comments from many organizations, specialty societies, and groups, including the AMA, the AMA RUC, and MedPAC concerning the creation of a group of experts.

Some commenters expressed support of such a panel. The commenters offered suggestions concerning its establishment and operations. The commenters stated that adequate resources and funding would be needed. The commenters viewed the panel as a vehicle to independently assess the AMA RUC recommendations. Several commenters stressed the importance of including consumers or purchasing representatives on such a panel and that the current process is too narrowly focused on resource costs. Commenters stated there is a need to restructure the payment system so that it appropriately values coordinated care delivery, encourages appropriate use of services, and rewards value and not volume.

Other commenters opposed creation of such a panel. The commenters stated that the current process has been successful, is transparent, and the rulemaking process provides additional oversight of the AMA RUC's recommendations. The commenters also stated that the AMA RUC has the technical knowledge and objective judgment to assist CMS in maintenance of the RVUs and that a superimposed panel would lack its insight. Commenters also stated that the addition of a separate group would increase demands on CMS; create coordination problems; and would be fiscally unsound and imprudent. Commenters noted that CMS and the AMA RUC have made strides in the misvalued codes initiative. Some of the commenters suggested that we consider enhancing the existing refinement panel process used to address the comments received on interim work RVUs (see section III for additional information on this process). Some commenters expressed concern that the refinement panels have not been adequately developed and that there is a lack of transparency.

MedPAC stated there are valid reasons that a panel should be established. It stated that CMS needs a regular source of expertise available to assist in valuing services and that such expertise is not solely the domain of the AMA RUC.

Response: We appreciate all of the comments and suggestions provided regarding the creation of a group of experts. We will take these comments into consideration as we continue to explore this issue.

We also appreciate the comments raised concerning the existing refinement panel process. Any revisions to this process would be discussed in future rulemaking.

G. Issues Related to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

This section addresses certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275). We proposed to revise our policies and regulations as described below in order to conform them to the statutory amendments.

1. Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services

Prior to the enactment of the MIPPA, section 1833(c) of the Act provided that for expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital, only 62½ percent of such expenses are considered to be incurred under Medicare Part B when determining the amount of payment and application of the Part B deductible in any calendar year. This provision is known as the outpatient mental health treatment limitation (the limitation), and has resulted in Medicare paying only 50 percent of the approved amount for outpatient mental health treatment, rather than the 80 percent that is paid for most other outpatient services.

Section 102 of the MIPPA amends the statute to phase out the limitation on recognition of expenses incurred for outpatient mental health treatment, which will result in an increase in the Medicare Part B payment for outpatient mental health services to 80 percent by CY 2014. When this section is fully implemented in 2014, Medicare will pay for outpatient mental health services at the same level as other Part B services. For CY 2010, section 102 of the MIPPA provides that Medicare will recognize 68¾ percent of expenses incurred for outpatient mental health treatment, which translates to a payment of 55 percent of the Medicare-approved amount. Section 102 of the MIPPA specifies that the phase out of the limitation will be implemented as shown in Table 6 provided that the patient has satisfied his or her deductible.

TABLE 6—IMPLEMENTATION OF SECTION 102 OF THE MIPPA

Calendar year	Recognized incurred expenses	Patient pays	Medicare pays
CY 2009 and prior calendar years	62.50%	50%	50%
CY 2010 and CY 2011	68.75%	45%	55%
CY 2012	75.00%	40%	60%
CY 2013	81.25%	35%	65%
CY 2014	100.00%	20%	80%

At present, § 410.155(c) of the regulations includes examples to illustrate application of the current limitation. We proposed to remove these examples from the regulations and, instead, provided examples in the CY 2010 PFS proposed rule (74 FR 33521), in our manual, and under provider education materials as needed. (See the CY 2010 PFS proposed rule (74 FR 33557) for the examples illustrating the application of the limitation in various circumstances as it is gradually reduced under section 102 of the MIPPA.) Section 102 of the MIPPA did not make any other changes to the outpatient mental health treatment limitation. Therefore, other aspects of the limitation will remain unchanged during the transition period between CYs 2010 and 2014. The limitation will continue to be applied as it has been in accordance with our regulation at § 410.155(b) which specifies that the limitation applies to outpatient treatment of a mental, psychoneurotic, or personality disorder, identified under the International Classification of Diseases (ICD) diagnosis code range 290–319. We use this ICD diagnosis code range, place of service code, and the procedure code to identify services to which the limitation applies.

Additionally, we proposed to make technical corrections to § 410.155(b)(2) in order to update and clarify the services already under these regulations to which the limitation does not apply. We proposed the following technical changes:

- Under § 410.155(b)(2)(ii), revise the regulation to specify the HCPCS code, M0064 (or any successor code), that represents the statutory exception to the limitation for brief office visits for the sole purpose of monitoring or changing drug prescriptions used in mental health treatment.
- At § 410.155(b)(2)(iv), we proposed to revise the regulation to add neuropsychological tests and diagnostic psychological tests to the examples of diagnostic services that are not subject to the limitation when performed to establish a diagnosis.
- Under § 410.155(b)(2)(v), we proposed to revise the regulation to specify the CPT code 90862 (or any successor code) that represents pharmacologic management services to which the limitation does not apply when furnished to treat a patient who is diagnosed with Alzheimer's disease or a related disorder.

Finally, we proposed to add a new paragraph (c) to § 410.155 that provides a basic formula for computing the limitation during the phase-out period from CY 2010 through CY 2013, as well as after the limitation is fully removed from CY 2014 onward.

The following is a summary of the comments we received regarding the proposed implementation of section 102 of the MIPPA.

Comment: All of the comments on section 102 of the MIPPA support the enactment by the Congress and implementation by CMS of this provision that will eventually achieve parity in payment for outpatient mental health services under the Medicare Part B program with the program's payment for other outpatient services. Most of the commenters describe the limitation as discriminatory and inequitable, and believe that it should have been eliminated a long time ago. The majority of the commenters believe that the elimination of the limitation will increase access to outpatient mental health services in the Medicare population. Therefore, elimination of the limitation will have a positive impact on Medicare beneficiaries because they will have to pay less out-of-pocket. Also, commenters believe that physicians and other providers of outpatient mental health care will be ''held harmless'' with respect to this change because, although they will collect less from the patient, they will ultimately be able to collect from the program the full Medicare approved amount for outpatient mental health services. The commenters that embrace our proposal to implement section 102 of the MIPPA, request that we maintain our proposal in the final rule, and encourage CMS to finalize section 102 of the MIPPA in a timely fashion.

Response: We appreciate the supportive comments received on our proposal to implement section 102 of the MIPPA and the encouragement to finalize our proposal. Also, we are grateful for the offerings made by a few commenters to assist in educating the provider community about section 102 of the MIPPA.

Comment: One commenter opposed two of our technical corrections to current regulations on the limitation at § 410.155(b)(2) and provided suggested changes. Specifically, under § 410.155(b)(2)(iv), we proposed to insert neuropsychological tests along with diagnostic tests that are performed to establish a diagnosis as diagnostic services that are not subject to the limitation. While this commenter has no issue with including neuropsychological tests, the commenter believes that a complete list of services would include outpatient consultation codes, all outpatient new patient and initial visit evaluation and management (E/M) codes, and the psychiatric diagnostic and evaluation interview codes (90801 and 90802). Accordingly, the commenter believes that if we expand the list of identified services not subject to the limitation by inserting neuropsychological tests only, without including the complete listing of services, we could be subjecting services inappropriately to the limitation.

On this particular technical correction, another commenter suggested that we should consider including a definition of ''diagnostic services'' to provide further guidance to the field on this issue.

The other technical correction that the commenter opposed is the provision under § 410.155(b)(2)(v) that lists medical management services billed under CPT code 90862 (or its successor code), as opposed to psychotherapy, as not being subject to the limitation when furnished to treat a patient who is diagnosed with Alzheimer's disease or a related disorder. The commenter believes that medical management services are not limited to those billed under CPT code 90862, but also

includes E/M of a patient with a mental illness using the outpatient E/M codes (CPT codes 99211 through 99215), and in a nursing facility, the subsequent nursing facility care E/M CPT codes (CPT codes 99307 through 99310). Hence, this commenter suggests that the proposed technical correction would unnecessarily and improperly limit the exception to only those instances when CPT code 90862 is billed. This commenter urged that the exception to the limitation for the treatment of a patient who is diagnosed with Alzheimer's disease or a related disorder should continue to include all non-psychotherapy services. Accordingly, this commenter suggested that the current language under regulations should be retained or that new language clarify that any outpatient service including CPT code 90862, E/M codes, and any other non-psychotherapy service provided to a patient with Alzheimer's disease or a related condition is not subject to the limitation.

One commenter who supports our implementation of the MIPPA provision commented that it is appropriate to update the list of services to which the limitation does not apply by specifying HCPCS code M0064, neuropsychological tests and diagnostic psychological tests, as well as CPT code 90862 when reporting services provided to a patient with Alzheimer's disease or a related disorder.

Response: The intent of our technical corrections to § 410.155 was to clarify, not to expand, our current policy. We intended to amend the existing regulations in a way that would update and clarify the already stated policy. Diagnostic psychological and neuropsychological tests are diagnostic services that are excluded from the limitation when performed to establish a diagnosis. The neuropsychological test codes were established years after the CPT codes for diagnostic psychological tests and that is why the reference to neuropsychological tests had not been included under current regulations. Additionally, in the context of psychiatric mental health services, the specific diagnostic services for which we have national policy regarding the limitation are the psychiatric diagnostic services under CPT codes 90801 and 90802, and, the CPT codes for diagnostic psychological and neuropsychological testing. In the absence of national policy concerning application of the limitation to diagnostic services billed under the outpatient consultation codes or the outpatient new patient and initial visit E/M codes, contractors use their discretion in making decisions about whether the limitation should be applied to such services under a variety of circumstances. To list these additional outpatient consultation and E/M codes as suggested by the commenter would represent an expansion of the current regulatory exception at § 410.155(b)(2)(iv).

However, we believe that if we revise the wording under § 410.155(b)(2)(iv) to specify that *psychiatric* diagnostic services billed under CPT codes 90801 and 90802 (or successor codes) and diagnostic psychological and neuropsychological tests billed under CPT code range 96101 through 96125 (or any successor code range) that are performed to establish a diagnosis are not subject to the limitation, we will address the commenter's concerns. Also, such a change will provide the field with specific guidance on our definition of ''diagnostic services'' in terms of mental health services.

We agree with the commenter that our technical correction to § 410.155(b)(2)(v) might have been read to restrict application of the exception to CPT code 90862. We will refrain from addressing specifically in the regulation outpatient E/M codes or nursing facility E/M codes. Rather, we will continue to leave in the hands of our contractors decisions as to whether the exception applies for these codes under particular circumstances. We have provided policy guidance to our contractors that medical management services furnished under CPT code 90862 to treat a patient diagnosed with Alzheimer's disease or a related disorder are not subject to the limitation. Therefore, we believe it is consistent with current national policy to amend the regulatory exception under § 410.155(b)(2)(v) to read, ''medical management such as that furnished under CPT code 90862 (or its successor code), as opposed to psychotherapy, furnished to a patient diagnosed with Alzheimer's disease or a related disorder.''

We received comments on issues that are outside the scope of our proposals for section 102 of MIPPA. These comments are not addressed in this final rule with comment.

2. Section 131: Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting Initiative (PQRI)

a. Program Background and Statutory Authority

The Physician Quality Reporting Initiative (PQRI) is a voluntary reporting program that provides an incentive payment to eligible professionals who satisfactorily report data on quality measures for covered professional services during a specified reporting period. Under section 1848(k)(3)(B) of the Act, the term ''eligible professional'' means any of the following a: (1) physician; (2) practitioner described in section 1842(b)(18)(C); (3) physical or occupational therapist or a qualified speech-language pathologist; or (4) qualified audiologist. The PQRI was first implemented in 2007 as a result of section 101 of Division B of the Tax Relief and Health Care Act of 2006—the Medicare Improvements and Extension Act of 2006 (Pub. L. 109–432) (MIEA–TRHCA), which was enacted on December 20, 2006. The PQRI was extended and further enhanced as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173) (MMSEA), which was enacted on December 29, 2007, and the MIPPA, which was enacted on July 15, 2008. Changes to the PQRI as a result of these laws, as well as information about the PQRI in 2007, 2008, and 2009, are discussed in detail in the CY 2008 PFS proposed rule (72 FR 38196 through 38204), CY 2008 PFS final rule with comment period (72 FR 66336 through 66353), CY 2009 PFS proposed rule (73 FR 38558 through 38575), and CY 2009 PFS final rule with comment period (73 FR 69817 through 69847). In addition, detailed information about the PQRI is available on the CMS Web site at *http://www.cms.hhs.gov/PQRI*.

We received several comments from the public on the CY 2010 PFS proposed rule related to the PQRI. General comments about the PQRI are addressed immediately below.

Comment: Many commenters supported proposed program changes for 2010, in particular those that make reporting flexible and less burdensome such as changes to the criteria for satisfactory reporting of measures groups (specifically, the removal of the requirement to report on consecutive patients), the proposed electronic health record-based (EHR-based) reporting mechanism, and the group practice reporting option.

Response: We appreciate the commenters' support of the changes proposed for the 2010 PQRI, many of which are finalized herein. We agree with commenters that many of the changes that we are finalizing for the 2010 PQRI, including the ones listed above, provide eligible professionals with greater flexibility and make reporting less burdensome.

Comment: Several commenters suggested that we consider and recommend to the Congress a modified version of the proposed option

presented by the Senate Finance Committee in the April 29, 2009, ''Description of Policy Options, Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs'' to add a new participation option allowing eligible professionals to receive PQRI incentive payments for 3 successive years if, on a triennial (every 3 year) basis, the eligible professional: (1) participates in a qualified American Board of Medical Specialties (ABMS) certification known as the Maintenance of Certification (MOC), or equivalent programs; and (2) completes a qualified MOC practice assessment. Such practice assessments typically consist of the use of performance measures to evaluate practice activities, which includes documentation of evidence of practice changes to improve quality, and re-evaluation to determine the effect of a change in the practice process or structure of care.

Response: Section 1848(m)(1) of the Act specifies the PQRI incentive amount for each program year and how the incentive payment amount is to be calculated for each reporting period during the program year. We do not have the authority to change how the incentive payment amount is determined and, therefore, cannot continue payments beyond the authorized program year.

With respect to the commenters' suggestion to provide PQRI incentive payments to eligible professionals who participate in an ABMS MOC program and complete a qualified MOC practice assessment, section 1848(m)(3)(A) of the Act dictates the criteria that eligible professionals must meet in order to be treated as satisfactorily submitting data on quality measures. These criteria include the reporting, by eligible professionals, of quality data on a standardized set of national consensus-based measures. For years after 2009, section 1848(m)(3)(D) of the Act gives us the discretion to revise the criteria for satisfactorily submitting data on quality measures. The proposed criteria for 2010, which did not explicitly include the option suggested by the commenters, were discussed in the CY 2010 PFS proposed rule (74 FR 33565 through 33569). We believe that basing criteria for satisfactory reporting solely on participation in an ABMS MOC and completion of a qualified MOC practice assessment without the submission of PQRI measures results would defeat the ability of CMS to analyze and compare eligible professional performance based on a standardized set of measures. PQRI is not based upon such qualifications, but rather on the submission of data on quality measures to measure eligible professional performance.

However, to the extent that ABMS member certification boards collect information on PQRI quality measures from eligible professionals, the ABMS member boards may qualify as registries under the PQRI and report such information to CMS on behalf of eligible professionals. Currently, one of the ABMS member boards has qualified as a CMS PQRI registry and successfully submitted data on PQRI measures on behalf of eligible professionals. This would allow eligible professionals to concurrently participate in an ABMS MOC and PQRI.

Comment: Several commenters suggested that we expand our education and outreach efforts so that professionals can gain a better understanding of the program, coding, and how to participate satisfactorily. Specifically, commenters suggested that we:

- Publish a list of professions that have participated in PQRI.
- Communicate potential incentive amounts that could be earned by an individual participant.
- Work with the AMA and other national stakeholder organizations to increase education and outreach for professionals about the requirements for satisfactorily reporting under various options.
- Use provider-neutral language, such as ''clinician'' or ''provider'' in describing the array of eligible professionals.

Response: We value the input received from stakeholders and participants who have provided constructive feedback and have collaborated with us to disseminate educational PQRI materials to eligible professionals in the health care community. We will continue to work with national and regional stakeholder organizations to educate their members on program requirements for satisfactory reporting.

We also plan to continue to host monthly national provider calls in which we expect to provide guidance on specific topics, including having our PQRI subject matter experts available to answer questions on the PQRI. Information about upcoming calls can be obtained from the CMS Sponsored Calls page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/04_CMSSponsoredCalls.asp#TopOfPage.* We will continue to make PQRI educational materials and other resources available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* as well. Updated educational materials and resources for the 2010 PQRI will be made available as soon as possible following publication of this final rule with comment period. Where appropriate, we will consistently use inclusive terminology such as ''eligible professionals'' rather than ''physicians'' in PQRI educational resources and related documents. We encourage eligible professionals to visit this Web site and to review the frequently asked questions (FAQs) found on this Web site. Eligible professionals are also encouraged to join the physician listserv to obtain periodic updates about the PQRI. Instructions for joining the listserv can be found at *https://list.nih.gov/archives/physicians-1.html.*

Finally, we anticipate conducting and publishing an evaluation of the 2008 PQRI similar to the ''PQRI 2007 Reporting Experience'' posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportFinal12032008CSG.pdf.* Although we have not yet finalized the operational details of our evaluation strategy, we expect the report to include participation rates by specialty/profession, associated trends in clinical performance and beneficiary outcomes, and other observable impacts on participants, the Medicare program, and beneficiaries.

Comment: Several commenters requested that we provide more detailed educational resources well in advance of the 2010 PQRI start date and provide enough lead time so that electronic systems may be updated to allow data capture for new or revised 2010 PQRI measures.

Response: We agree with the commenters that it is desirable to provide final measure specifications and other educational resources sufficiently in advance of the start of a new program year to allow reasonable time for professionals to analyze new or revised reporting options and measures, and implement any needed changes in their office workflows so that they may accurately capture and satisfactorily submit data on a selection of measures applicable to their practice. We are aware that such lead time would also help the eligible professionals' specialty or professional societies to prepare to support the professionals' selection of relevant measures. Having detailed information on measures available in advance also enhances the ability of vendors (such as practice-management software, billing services, and electronic health record vendors) to support professionals' successful implementation of revised data capture processes for the measures. We are

targeting finalization and publication of the detailed specifications for all 2010 PQRI measures on the CMS Web site, by November 15, 2009, but no later than December 31, 2009. The detailed specifications include instructions for reporting and identifying the circumstances in which each measure is applicable. The specifications for measures in the final listing for the 2010 PQRI, including a measure's title, remain potentially subject to corrections until the start of the 2010 reporting period. We are also committed to making other educational resources for the 2010 PQRI available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* as quickly as possible after publication of this final rule with comment period.

As discussed below, to assist eligible professionals who may need additional time to make updates to their electronic systems or practice workflows, we also are finalizing a 6-month reporting period beginning July 1, 2010, for claims-based reporting of individual measures. Thus, the 6-month reporting period will be available for both those who wish to report individual measures, as well as measures groups through claims or a qualified registry.

Comment: Some commenters requested that we provide detailed data used to determine that a professional failed to report on 80 percent of eligible cases and to inform them about what they need to do to rectify errors.

Response: We considered recommendations about PQRI participant feedback reports as part of an ongoing dialogue with the stakeholder and participant community. We convened a multi-specialty focus group and have revised the design and content of the 2008 PQRI feedback reports, which were recently released. These revised feedback reports include more detailed information at the individual eligible professional level than was provided in the 2007 PQRI feedback reports.

Comment: Several commenters stated that the 2007 feedback reports were too difficult to obtain, did not provide sufficient detailed information to allow correction, and were not available on an interim basis to prevent eligible professionals from making the same errors in the following program year.

Response: To address concerns expressed about our secure method used to obtain the feedback reports (which requires eligible professionals to register and obtain an Individuals Authorized Access to CMS Computer Services, or IACS, account), we identified an alternative feedback report request process for individual eligible professionals requesting NPI level reports, which allows an individual participant to obtain his or her own feedback report through their carrier or MAC after providing appropriate identification. Information about this new process is available on the PQRI section of the CMS Web site and was discussed on the October 15, 2009, PQRI national provider call.

We have assessed the feasibility of providing some type of interim feedback report to participants. We have determined, however, detailed, accurate, participant-level interim feedback reports cannot be provided in an appropriately secure access environment. However, given that the most prevalent underlying reasons for failure to meet incentive eligibility are due to (1) failure by the professional to identify and report on at least 80 percent of denominator-eligible cases for the measures selected, and (2) quality data code errors due to incorrect or insufficient coding, we have determined that an aggregate-level quality data submission error report could be published on a quarterly basis on the PQRI section of the CMS Web site, to provide information on the types of submission errors found for each measure. Following the posting of the ''PQRI 2007 Reporting Experience'' report, we have continued to post updated error reports on a quarterly basis on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*.

Comment: Several commenters who participated in the 2008 PQRI have commented on the lack of timely feedback reports and incentive payments.

Response: For claims-based reporting, PQRI analysis of individual professionals' claims begins after the conclusion of the program year when all claims have been processed. Conducting individual-level analysis on a portion of a professional's claims during the program year would result in inaccurate data and presents a significant expense to CMS. We acknowledge participating professionals' need for interim information on the accuracy of their quality reporting through claims. Therefore, we have posted aggregate-level information on the PQRI section of the CMS Web site on a quarterly basis describing quality-data code submission errors that we observe on claims for each PQRI measure and anticipate continuing to do so in the future.

In addition, many registries provide interim feedback to their clients. Therefore, eligible professionals who participate in PQRI through a qualified registry may be able to receive interim feedback from the registry and have the opportunity to correct those errors prior to the program year data submission deadline.

Comment: Several commenters requested that we establish a formal appeals process for those professionals who participate in PQRI but do not qualify for the incentive payment.

Response: Section 1848(m)(5)(e) of the Act provides that with respect to the PQRI there shall be no administrative or judicial review under section 1869, section 1879, or otherwise of (1) The determination of measures applicable to services furnished by eligible professionals; (2) the determination of satisfactory reporting; and (3) the determination of any incentive payment. Since 2007, we have addressed inquiries about the PQRI through the question-and-answer sessions held during monthly PQRI national provider calls and open door forums. More recently, a dedicated Help Desk has been implemented to respond to participants' inquiries related to all aspects of the PQRI, including assisting eligible professionals in understanding why they did not receive a PQRI incentive payment. The Help Desk is available from 7 a.m. to 7 p.m. CT and can be reached by phone at (866) 288–8912 or via e-mail at *qnetsupport@sdps.org*.

Comment: Several commenters expressed the need to evaluate the impact of PQRI and make evaluation results available to stakeholders. Some commenters stated that an evaluation of outcomes achieved is needed before deciding whether to expand the program, impose penalties, or make participation mandatory. One commenter noted that such an evaluation is needed to restore confidence in the PQRI since the program's validity within the eligible professional community has been compromised due to the PQRI being rushed. Other commenters urged us to provide medical specialty organizations with the PQRI data files so that they may perform an independent analysis to assist CMS to improve the clinical appropriateness of physician quality measures and better understand or correct potential barriers to satisfactory reporting.

Response: We have conducted and published an evaluation of the 2007 PQRI and have posted the ''PQRI 2007 Reporting Experience'' on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportFinal12032008CSG.pdf*. We anticipate conducting a similar evaluation of the 2008 PQRI and expect to include participation rates by

specialty/profession, associated trends in clinical performance and beneficiary outcomes, and other observable impacts on participants, the Medicare program, and beneficiaries. Although we have not yet finalized the operational details of our evaluation strategy for the 2008 PQRI and beyond, we do anticipate making the results of the evaluation, at the national level, available to the public. We also may make publicly available the results of such analyses aggregated at other meaningful levels (for example, State, specialty, or profession). We do not at this time plan to make results publicly available in a format or with content that would enable identification of individual professionals or specific practices' reporting or performance results.

Comment: Several commenters urged CMS to expand PQRI in a manner that would allow participation by therapy professionals who practice in institutional settings such as hospitals, rehabilitation facilities, and skilled nursing facilities and submit their individual National Provider Identifier (NPI) either through claims or through registry-based reporting.

Response: As we stated in the CY 2008 PFS final rule with comment period (74 FR 69820 through 69821), we agree with the goal of offering the opportunity to participate in PQRI to as many eligible professionals as feasible and practical, consistent with the statutory requirements. Except for group practices participating in the group practice reporting option, which begins in 2010, the determination of satisfactory reporting and the calculation of any earned incentive payment amount must be determined at the individual professional level, regardless of the method of reporting quality data. For therapy professionals who practice in institutional settings, we cannot make the determination of satisfactory reporting and calculate earned incentive payment amounts at the individual eligible professional level without extensive modifications to the claims processing systems of CMS and providers, which would represent a material administrative burden to us and to providers. It would also require modifications to the industry standard claims formats, which would require substantial time to effect through established processes and structures that we do not maintain or control. We have also found that most institutions that employ therapists do not tie the individual therapist to the service rendered to an individual patient. Instead, therapists are hired for a fixed number of hours per day per week. In this case, there are no provider identifiers available to use in processing these claims.

Comment: Several commenters indicated that we should convert PQRI from a pay-for-reporting program to a pay-for performance program, stating that reporting on quality measures is not sufficient and that consumers need performance data for informed choice based on quality and value.

Response: Our plans for a report to Congress on transitioning to a physician value-based purchasing program are discussed in section II.G.4. of this final rule with comment period.

Comment: Some commenters expressed concern that the impact analysis of the estimated costs for participation by professionals for claims-based, registry-based, and EHR-based reporting contained in the CY 2010 PFS proposed rule (74 FR 33664 through 33665) are too low or inaccurate and should be rectified in the final rule. One commenter noted that one estimate of the cost for a practice to participate in PQRI ranges from $55,000 to $1.3 million. Other commenters cited an example from a practice with 1 full-time eligible professional and 1 part-time eligible professional where it was determined that the cost for claims-based reporting in PQRI was $1,780 per year, or $1,186 per eligible professional. Some commenters suggested that we conduct a survey of successful PQRI participants and/or data submission vendors to determine all participation costs and publish survey results in future rules.

Response: As stated in the CY 2010 PFS proposed rule (74 FR 33664), individual eligible professionals and group practices may have different processes for integrating the PQRI into their practices' work flows. Therefore, it is difficult for us to accurately quantify the cost burden because it would vary with each eligible professional by the number of measures applicable to the eligible professional, the number of measures on which an eligible professional chooses to report, the complexity of the measure(s) chosen by the eligible professional, the eligible professional's patient population and how frequently the professional's selected measure(s) apply to the professional's patient population, the eligible professional's familiarity, understanding, and experience with the PQRI, and the reporting option selected by the eligible professional. To be able to provide any cost estimates we had to use certain assumptions with respect to the number of measures reported on and the number of reporting instances per eligible professional. Given that practices vary in size and patient population, these assumptions will not hold true for every practice participating in PQRI and some practices' costs associated with PQRI participation will exceed the estimates provided in our cost estimates while other practices will have costs below our estimates. We cannot assess the examples offered by commenters without additional information on the number of measures reported by each eligible professional in the practice and the number of reporting instances per eligible professional. We will consider, however, the commenters' suggestions for future years but believe that it would be unlikely that we would be able to obtain a representative sample of survey respondents given the many variables that impact participation costs.

Comment: A specific concern cited by commenters with respect to the impact analysis was that reliance on historical data from the Physician Voluntary Reporting Program (PVRP) is inappropriate and does not take into consideration the development and maintenance of new workflows necessary to participate in PQRI and the new measure, measure specification changes and reporting option changes that occur on an annual basis.

Response: Information from the PVRP was used solely for developing cost estimates for participation in PQRI through the claims-based reporting mechanism; not through other reporting mechanisms. To develop our cost estimates for claims-based reporting, we applied information from PVRP on how much time it takes one eligible professional, in a median practice, to report one measure one time through claims to our assumptions. We recognize that the PVRP cost estimates are historical, but we do not believe that the process for reporting measures through claims has changed significantly from PVRP to PQRI in a way to considerably change the amount of time it takes one eligible professional to report one measure one time through claims. However, for our impact analysis, we did use a higher average practice labor cost than what was indicated in the information from the PVRP (that is, we used $55 per hour instead of $50 per hour) to account for increases in labor costs over time (74 FR 33655).

Comment: Other commenters had specific concerns about the estimates provided for participation in PQRI via registries. Some commenters offered anecdotal information that the annual cost to one practice of participating in a specific registry is approximately $3,000. Another commenter believed that more than 5 minutes is needed for

an eligible professional to authorize a registry to submit quality measure results and numerator and denominator data on their behalf. Other commenters were concerned that our estimate of $1,500 to $5,000 to purchase an EHR product was too low. One commenter noted that EHR systems have capital costs of over $1 million per year. Another commenter noted that researchers recently found that it would cost about $124,000 for a single doctor or small practice to upgrade to EHRs over 5 years.

Response: We appreciate the input from commenters and have taken the additional information provided by commenters into consideration to revise the estimates associated with registry and EHR reporting where appropriate in sections XIII.E.2 and XI. of this final rule with comment period.

For registry reporting, however, we note that many registries offer additional services beyond what is required to participate in PQRI. In the example provided by commenters, it is not clear whether those costs that are not related to reporting PQRI quality measure results and numerator and denominator data on PQRI measures have been taken into consideration and excluded. Our impact analysis is limited to the incremental cost of participating in PQRI.

b. Incentive Payments for the 2010 PQRI

For 2010, section 1848(m)(1)(B) of the Act authorizes the Secretary to provide an incentive payment equal to 2.0 percent of the estimated total Medicare Part B PFS allowed charges (based on claims submitted not later than 2 months after the end of the reporting period) for all covered professional services furnished during the reporting period for 2010. Although PQRI incentive payments are only authorized through 2010 under section 1848(m)(1)(A) of the Act, section 1848(k)(2)(C) of the Act provides for the use of consensus-based quality measures for the PQRI for 2010 and subsequent years.

The PQRI incentive payment amount is calculated using estimated Medicare Part B PFS allowed charges for all covered professional services, not just those charges associated with the reported quality measures. ''Allowed charges'' refers to total charges, including the beneficiary deductible and coinsurance, and is not limited to the 80 percent paid by Medicare or the portion covered by Medicare where Medicare is secondary payer. Amounts billed above the PFS amounts for assigned and non-assigned claims will not be included in the calculation of the incentive payment amount. In addition, since, by definition under section 1848(k)(3)(A) of the Act, ''covered professional services'' are limited to services for which payment is made under, or is based on, the PFS and which are furnished by an eligible professional, other Part B services and items that may be billed by eligible professionals but are not paid under or based upon the Medicare Part B PFS are not included in the calculation of the incentive payment amount.

Under section 1848(m)(6)(C) of the Act, the ''reporting period'' for the 2008 through 2011 PQRI is defined to be the entire year, but the Secretary is authorized to revise the reporting period for years after 2009 if the Secretary determines such ''revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden.''

We are also required by section 1848(m)(5)(F) of the Act to establish alternative criteria for satisfactorily reporting and alternative reporting periods for registry-based reporting and for reporting measures groups. Therefore, eligible professionals who meet the alternative criteria for satisfactorily reporting for registry-based reporting and for reporting measures groups for the 2010 alternative reporting periods for registry-based reporting and for reporting measures groups will also be eligible to earn an incentive payment equal to 2.0 percent of the estimated total Medicare Part B PFS allowed charges for all covered professional services furnished by the eligible professional during the alternative reporting periods for 2010 PQRI registry-based reporting or for reporting measures groups.

Prior to 2010, the PQRI was an incentive program in which determination of whether an eligible professional satisfactorily reported quality data was made only at the individual professional level, based on the NPI. Although the incentive payments were made to the practice(s) represented by the Tax Identification Number (TIN) to which payments are made for the individual professional's services, there were no incentive payments made to the group practice based on a determination that the group practice, as a whole, satisfactorily reported PQRI quality measures data. To the extent individuals (based on the individuals' NPIs) satisfactorily reported data on PQRI quality measures that were associated with more than one practice or TIN, the determination of whether an eligible professional satisfactorily reported PQRI quality measures data was made for each unique TIN/NPI combination. Therefore, the incentive payment amount was calculated for each unique TIN/NPI combination and payment was made to the holder of the applicable TIN.

However, section 1848(m)(3)(C)(i) of the Act requires that by January 1, 2010, the Secretary establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures for the PQRI for covered professional services for a reporting period, if, in lieu of reporting measures under subsection (k)(2)(C), the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary. Therefore, beginning with the 2010 PQRI, group practices that satisfactorily submit data on quality measures also would be eligible to earn an incentive payment equal to 2.0 percent of the estimated total Medicare Part B PFS allowed charges for all covered professional services furnished by the group practice during the applicable reporting period. As required by section 1848(m)(3)(C)(iii) of the Act, payments to a group practice by reason of the process described above would be in lieu of the PQRI incentive payments that would otherwise be made to eligible professionals in the group practice for satisfactorily submitting data on quality measures. Therefore, an individual eligible professional who is participating in the group practice reporting option as a member of a group practice would not be able to separately earn a PQRI incentive payment as an individual eligible professional under that same TIN (that is, for the same TIN/NPI combination).

The following is summary of the comments we received regarding the 2010 PQRI incentive payment amount.

Comment: One commenter expressed support of the proposed extension of the PQRI incentive related to the group practice reporting option.

Response: We appreciate the commenter's support of the extension of the PQRI incentive to group practices.

Commenter: One commenter expressed a concern that the PQRI incentive payment is calculated as a percentage of the total Medicare billing of the individual eligible professional. The commenter expressed concern that for an equal amount of relative value unit work, eligible professionals in lower GPCI localities will receive as

much as 38 percent less PQRI payment for the same work, time, and effort used in providing quality care than eligible professionals in higher GPCI localities. The commenter suggested that PQRI incentive payment calculations should not be geographically adjusted and recommended that we change the basis of the incentive to RVUs rather than dollars billed to Medicare.

Response: While we acknowledge the effect of the GPCI on the calculation of the PQRI incentive amount, we do not have authority to change the basis for the calculation of the incentive amount, which is defined by section 1848(m)(1) of the Act.

Comment: A commenter requested clarification on whether radiopharmaceuticals are included in the PQRI and electronic prescribing incentive payments (see section II.G.5. of this final rule with comment period for further discussion of the E-Prescribing Incentive Program).

Response: Medicare Part B PFS allowed charges for radiopharmaceuticals have been included for determining the PQRI and electronic prescribing incentive payments. Radiopharmaceuticals are included as part of section 1861(s)(4) of the Act, which is incorporated into the list of PFS services cited in section 1848(j)(3) of the Act, and therefore, are part of the PQRI and electronic prescribing incentive calculations.

The relevant radiopharmaceutical codes are paid on the basis of invoices submitted by physicians. Such invoices are considered similar to contractor priced items or services. In addition, radiopharmaceuticals are classified as A codes (A9500–A9699) which inadvertently have not previously been included in Addendum B. Commencing with CY 2010, radiopharmaceuticals will be included in Addendum B as MPFSDB covered charges.

Furthermore, FAQ 8545, which can be accessed via the PQRI section of the CMS Web site, states that for ''PQRI participants who report satisfactorily, radiopharmaceuticals furnished as part of a covered professional service will be included in the basis of total Medicare Part B PFS allowed charges on which the incentive is calculated.''

No changes in radiopharmaceutical payment will be necessary. Payment will continue to be contractor-priced on the basis of invoices under the physician fee schedule.

c. 2010 Reporting Periods for Individual Eligible Professionals

As we indicated above, section 1848(m)(6)(C) of the Act defines ''reporting period'' for 2010 to be the entire year. Section 1848(m)(6)(C)(ii) of the Act, however, authorizes the Secretary to revise the reporting period for years after 2009, if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. In addition, section 1848(m)(5)(F) of the Act requires, for 2008 and subsequent years, the Secretary to establish alternative reporting periods for reporting groups of measures and for registry-based reporting.

In the CY 2010 PFS proposed rule (74 FR 33560), we proposed that the 2010 PQRI reporting period for the reporting of individual PQRI quality measures through claims or a qualified EHR would be the entire year (that is, January 1, 2010 through December 31, 2010). We also proposed to retain the 2 alternative reporting periods from the 2008 and 2009 PQRI for reporting measures groups and for registry-based reporting: (1) the entire year; and (2) a 6-month reporting period beginning July 1.

We solicited comments on these proposals and the decision not to propose a 6-month reporting period for claims-based reporting of individual PQRI quality measures. The following is a summary of the comments received regarding the proposed reporting periods.

Comment: Although a majority of the commenters supported the proposed reporting periods, we received several comments requesting that CMS retain or add a 6-month reporting period for claims-based reporting of individual measures. Many commenters requested this additional reporting period because they believe that doing so would encourage PQRI participation by allowing more time for eligible professionals to implement PQRI into their practice workflows and providing an opportunity for those who are hesitant to continue participating in PQRI until they receive feedback from the previous year to do so as well. Many commenters noted that reporting measures groups or reporting through a registry is not an option for them. Other commenters suggested that we maintain the 6-month reporting period for claims-based reporting of individual measures to maintain flexibility and uniformity in reporting periods for all PQRI reporting options to reduce confusion since many eligible professionals already believe that they can start claims-based reporting of individual measures in July.

Some commenters also requested that we have a 6-month reporting period for claims-based reporting of individual measures for situations in which an eligible professional who was planning to report through an alternative reporting mechanism may have to revert to claims-based reporting during the year, such as when an eligible professional's EHR system requires re-installation or significant maintenance or upgrades or when it takes longer for a practice to acquire a new EHR system than anticipated.

Response: Although many commenters requested that we ''retain'' the 6-month reporting period for claims-based reporting of individual measures, we would like to clarify there was no 6-month reporting period for claims-based reporting of individual quality measures available for either the 2008 or 2009 PQRI. In the 2008 and 2009 PQRI, the 6-month reporting period beginning July 1 was only available to eligible professionals who chose to report on measures groups or chose registry-based reporting (of either individual measures or measures groups). Prior to 2010 we did not have the authority to change the reporting period for claims-based reporting of individual measures, which is defined by section 1848(m)(6)(C)(i)(II) of the Act to be the entire year for 2008, 2009, 2010, and 2011. The only program year in which the reporting period was defined by statute to be the 6-month period beginning July 1 was the 2007 PQRI.

However, as a result of the compelling arguments presented by commenters, we will exercise our authority under section 1848(m)(6)(C)(ii) of the Act to revise the reporting period for the 2010 PQRI. Thus, in addition to the 12-month reporting period beginning January 1, 2010, we are finalizing a 6-month reporting period beginning July 1, 2010, available for claims-based reporting of individual measures for the 2010 PQRI.

Comment: One commenter supported not adding a 6-month reporting period for claims-based reporting of individual measures based on the assumption that we would eliminate claims-based reporting after 2010.

Response: As we stated in the CY 2010 PFS proposed rule (74 FR 33561), our ability to reduce or eliminate our reliance on claims-based reporting is contingent on there being an adequate number and variety of registries available and/or EHR reporting options. Since it is unlikely that there will be an adequate number of measures available for EHR reporting in 2011 for us to solely rely on registry and EHR reporting, we anticipate continuing to offer claims-based reporting options for the PQRI beyond 2010. Therefore, for the reasons discussed above, we believe that a 6-month reporting period for claims-based reporting of individual

measures should be available to the extent that claims-based reporting of individual measures continues to be an available option for eligible professionals.

Comment: One commenter requested that we provide a ''clarifying definition of the term 'qualified' '' with respect to the proposed 2010 PQRI reporting periods. The commenter noted that there is a similar term in industry use and a definition would help to avoid confusion.

Response: We are unclear as to how the term ''qualified'' relates to the PQRI reporting periods and believe that the commenter may be referring to our use of the term ''qualified'' with respect to registry and EHR reporting. As proposed for the 2010 PQRI (74 FR 33563 through 33565), for purposes of the PQRI, a ''qualified'' registry is one that has self-nominated to be able to submit PQRI quality measures results and numerator and denominator data on PQRI quality measures or measures groups on behalf of eligible professionals and that has been vetted by CMS to ensure the registry's meets certain technical and other requirements. Similarly, a ''qualified'' EHR vendor is one that has self-nominated to have one or more of its EHR products vetted by CMS to ensure that the product(s) meets certain technical and other requirements. Eligible professionals who wish to submit PQRI measures via an EHR may only use qualified EHR products to do so.

For the reasons discussed above and based on the comments, for 2010, we will retain a 12-month reporting period beginning January 1, 2010, which will be available for all reporting mechanisms and regardless of whether an individual eligible professional chooses to report on 2010 PQRI individual measures or measures groups. In addition, we are adopting a 6-month reporting beginning July 1, 2010, for claims-based and registry-based reporting of 2010 PQRI individual measures or measures groups. This 6-month reporting period will not be available for EHR-based reporting in 2010. Once we have additional experience with EHR reporting in PQRI we may consider including a 6-month reporting period for EHR reporting in future years.

In addition, an eligible professional who satisfactorily reports 2010 PQRI measures or measures groups through claims or a qualified registry for the 6-month reporting period will qualify to earn a PQRI incentive payment equal to 2.0 percent of his or her total estimated Medicare Part B PFS allowed charges for covered professional services furnished between July 1, 2010 and December 31, 2010 only. As required by section 1848(m)(1)(A) of the Act, the incentive payment will be calculated based on the eligible professional's charges for covered professional services furnished during the applicable reporting period only.

d. 2010 PQRI Reporting Mechanisms for Individual Eligible Professionals

When the PQRI was first implemented in 2007, there was only 1 reporting mechanism available to submit data on PQRI quality measures. For the 2007 PQRI, the only way that eligible professionals could submit data on PQRI quality measures was by reporting the appropriate quality data codes on their Medicare Part B claims (claims-based reporting). For the 2008 PQRI, we added a second reporting mechanism as required by section 1848(k)(4) of the Act, so that eligible professionals could submit data on PQRI quality measures to a qualified PQRI registry and request the registry to submit PQRI quality measures results and numerator and denominator data on the 2008 PQRI quality measures or measures groups on their behalf (registry-based reporting). For the 2009 PQRI, we retained the 2 reporting mechanisms used in the 2008 PQRI (that is, claims-based reporting and registry-based reporting) for reporting individual PQRI quality measures and for reporting measures groups.

To promote the adoption of EHRs, we also conducted limited testing of a third reporting mechanism for the 2008 and 2009 PQRI, which was the submission of clinical quality data extracted from an EHR, or the EHR-based reporting mechanism. No incentive payment was available to those eligible professionals who participated in testing the EHR-based reporting mechanism.

For the 2010 PQRI, we proposed to retain the claims-based reporting mechanism and the registry-based reporting mechanism. In addition, we proposed to accept PQRI quality measure data extracted from a qualified EHR product (that is, an EHR successfully completing the 2009 EHR Testing Program) for a limited subset of the proposed 2010 PQRI quality measures, as identified in Table 20 of the CY 2010 PFS proposed rule, contingent upon the successful completion of our 2009 EHR data submission testing process and a determination based on that testing process that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible. We solicited comments on the proposed reporting mechanisms for the 2010 PQRI, including the proposal to add an EHR-based reporting mechanism to the 2010 PQRI, contingent upon the successful completion of our 2009 EHR data submission testing process and a determination that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible.

We also discussed in the CY 2010 PFS proposed rule how we may consider significantly limiting the claims-based mechanism of reporting clinical quality measures for the PQRI after 2010. We solicited comments on our intent to lessen our reliance on the claims-based reporting mechanism for the PQRI beyond 2010.

The following is a summary of the comments received with regard to the proposed 2010 PQRI reporting mechanisms and our intent to lessen reliance on the claims-based reporting mechanism for the PQRI beyond 2010.

Comment: A majority of the commenters agreed with our reasons for lessening our reliance of claims-based reporting, supported alternative reporting mechanisms, or agreed that we should eventually transition away from claims-based reporting. At the same time, however, many of these same commenters urged us to reconsider limiting or eliminating claims-based reporting in 2011. Many commenters noted that claims-based reporting is currently the only option available for many eligible professionals and is the only reporting mechanism that is available to all eligible professionals. Other commenters cited claims-based reporting as the most convenient and cost-effective reporting mechanism available to eligible professionals, particularly solo practitioners and those in small practices. Also, the commenters noted that the EHR-based reporting mechanism initially will only be available on a limited basis so we should wait until EHR-based reporting becomes well established before transitioning away from claims-based reporting.

Response: We acknowledge the commenters' concerns that prematurely eliminating the claims-based reporting mechanism could create barriers to participation. While our goal continues to be to eventually phase-out claims-based reporting, our ability to reduce or eliminate our reliance on claims-based reporting is contingent on there being an adequate number and variety of registries available and/or EHR reporting options. As we stated previously, since it is unlikely that there will be an adequate number of measures available for EHR reporting in 2011 for us to completely eliminate the claims-based reporting mechanism, we

anticipate continuing to offer claims-based reporting options for the PQRI beyond 2010. We may, however, avoid introducing new claims-based measures and increasingly limit the circumstances in which claims-based reporting is an available reporting mechanism in order to encourage wider adoption of registry or EHR-based reporting.

Comment: One commenter recommended that, as we move towards reducing reliance on claims-based reporting for PQRI and increase registry-based and EHR-based options, we require registries and EHR vendors to seek and obtain a license to use the measures from the measure developers.

Response: PQRI measure specifications are developed in consultation with the measure developers and are made available to the public via posting on the PQRI section of the CMS Web site. Registries must use the PQRI measure specifications posted on the PQRI section of the CMS Web site to calculate reporting or performance unless otherwise stated. Similarly, eligible professionals who choose to participate in PQRI via the EHR-based reporting mechanism must use PQRI measure specifications to do so. We believe use of these measure specifications, regardless of the method by which quality data is submitted to PQRI for analysis, ensures consistent use and reporting of the measures.

Comment: One commenter expressed concern that registry and EHR-based reporting may not account for changes in patient condition over the course of the reporting period, and suggested reporting options be restructured so that results submitted using any method for a given patient population and a specific time period are identical.

Response: Regardless of the reporting mechanism an eligible professional selects to participate in PQRI, measure specifications and instructions for reporting a measure are consistent across mechanisms. If the measure specifications are analyzed properly by a registry or EHR vendor, the results should be very close or identical to the results for claims-based reporting, as the commenter requested.

Comment: Several commenters recommended uniform data submission deadlines be established across all reporting mechanisms. The commenter noted specifically that the proposed deadline for submission of data on PQRI quality measures for EHR-based reporting and for registry reporting was March 31, 2011 while the proposed deadline for submission of data on PQRI quality measures for other reporting mechanisms was February 28, 2011.

Response: We agree that the deadline for submission of data on PQRI quality measures for EHR-based reporting should be consistent with the deadline for submission of data on PQRI quality measures for claims-based reporting. Therefore, eligible professionals participating in the 2010 PQRI via EHR reporting or claims reporting will be required to submit all data on 2010 PQRI quality measures by no later than February 28, 2011 in order for the data to be included in the 2010 PQRI data analysis. Whereas CMS receives the raw data elements from eligible professionals for EHR and claims-based reporting and calculates the eligible professionals' reporting and performance results, registries must calculate and submit eligible professionals' quality measure reporting and performance results to us. In implementing registry-based reporting for the 2008 PQRI, we determined that a February deadline for submission of data on PQRI quality measures would be insufficient for registries to collect the data from their participants, calculate PQRI quality measure results, and submit the quality measure results and numerator and denominator data to CMS. Thus, registries are given additional time beyond February 28, 2011, to submit their data on behalf of participating eligible professionals. Eligible professionals participating in the 2010 PQRI via registry reporting should check with their selected registry regarding the registry's deadline for submission of data on PQRI quality measures from eligible professionals.

For the reasons discussed above and based on the comments received, as well as our experience with the EHR testing process to date, we are finalizing the option for an eligible professional to be able to choose to report data on 2010 PQRI quality measures through claims, through a qualified registry, or through a qualified EHR product (contingent on there being a qualified 2010 EHR product). Depending on which PQRI individual quality measures or measures groups an eligible professional selects, however, one or more of the 2010 reporting mechanisms may not be available for reporting a particular 2010 PQRI individual quality measure or measures group. The 2010 reporting mechanism(s) through which each 2010 PQRI individual quality measure and measures group can be reported is identified in Tables 11 through 27 of this final rule with comment period.

Regardless of the reporting mechanism chosen by an eligible professional, there is no requirement for the eligible professional to sign up or register to participate in the PQRI. However, there may be some requirements for participation through a specific reporting mechanism that are unique to that particular reporting mechanism. In addition to the criteria for satisfactory reporting of individual measures and measures groups described in sections II.G.2.e. and II.G.2.f. of this final rule with comment period, eligible professionals must ensure that they meet all requirements for their chosen reporting mechanism as described in sections II.G.2.d.1. through II.G.2.d.3. of this final rule.

(1) Final Requirements for Individual Eligible Professionals Who Choose the Claims-Based Reporting Mechanism

For eligible professionals who choose to participate in the 2010 PQRI by submitting data on individual quality measures or measures groups through the claims-based reporting mechanism, we proposed that the eligible professional would be required to submit the appropriate PQRI quality data codes on the professionals' Medicare Part B claims. As in previous years, an eligible professional would be permitted to start submitting the quality data codes for the eligible professional's selected individual PQRI quality measures or measures group at any time during 2010. Please note, however, that as required by section 1848(m)(1)(A) of the Act, all claims for services furnished between January 1, 2010 and December 31, 2010, would need to be processed by no later than February 28, 2011, to be included in the 2010 PQRI analysis.

We did not receive any comments specific to the requirements for individual eligible professionals who choose claims-based reporting. Therefore, we are finalizing the requirements as proposed. Eligible professionals should refer to the ''2010 PQRI Implementation Guide'' to facilitate satisfactory reporting of quality data codes for 2010 PQRI individual measures on claims and to the ''Getting Started with 2010 PQRI Reporting of Measures Groups'' to facilitate satisfactory reporting of quality data codes for 2010 PQRI measures groups on claims. By no later than December 31, 2009, both of these documents will be posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/pqri.*

(2) Final Requirements for Individual Eligible Professionals Who Choose the Registry-Based Reporting Mechanism

In order to report quality measures results and numerator and denominator data on the 2010 PQRI individual quality measures or measures group through a qualified clinical registry, we

proposed that eligible professionals would need to enter into and maintain an appropriate legal arrangement with a qualified 2010 PQRI registry. Such arrangements would provide for the registry's receipt of patient-specific data from the eligible professional and the registry's disclosure of quality measures results and numerator and denominator data on PQRI quality measures or measures groups on behalf of the eligible professional to CMS. Thus, the registry would act as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191) (HIPAA) Business Associate and agent of the eligible professional. Such agents are referred to as ''data submission vendors.'' The ''data submission vendors'' would have the requisite legal authority to provide clinical quality measures results and numerator and denominator data on individual quality measures or measures groups on behalf of the eligible professional for the PQRI. The registry, acting as a data submission vendor, would submit CMS-defined registry-derived measures information to the CMS designated database for the PQRI, using a CMS-specified record layout. The record layout will be provided to the registry by CMS.

To maintain compliance with applicable statutes and regulations, our program and its data system must maintain compliance with the HIPAA requirements for requesting, processing, storing, and transmitting data. Eligible professionals that conduct HIPAA covered transactions also would need to maintain compliance with the HIPAA requirements.

We proposed that eligible professionals choosing to participate in PQRI by submitting quality measures results and numerator and denominator data on PQRI individual quality measures or measures groups through the registry-based reporting mechanism for 2010 would be required to select a qualified PQRI registry and submit information on PQRI individual quality measures or measures groups to the selected registry in the form and manner and by the deadline specified by the registry (74 FR 33562).

In addition to meeting the above proposed requirements specific to registry-based reporting, we proposed that eligible professionals who choose to participate in PQRI through the registry-based reporting mechanism would need to meet the relevant criteria proposed for satisfactory reporting of individual measures or measures groups that all eligible professionals must meet in order to qualify to earn a 2010 PQRI incentive payment (74 FR 33563).

The following is a summary of the comments we received regarding the proposed requirements for individual eligible professionals who choose the registry-based reporting mechanism for the 2010 PQRI.

Comment: We received multiple comments requesting that we not wait until the qualified 2009 registries successfully submit their 2009 PQRI data to publish the list of qualified registries for 2010 PQRI. Commenters suggested that approved registries and the vetting of the self-nominated registries must occur earlier in the reporting year to allow eligible providers time to review and select an appropriate registry for their needs. A few commenters suggested that the list of eligible registries be made available prior to the start of the reporting period and one commenter recommended these registries be announced at least one month prior to the reporting period. Another commenter suggested the delay in listing qualified registries for 2010 PQRI would penalize 2009 qualified registries and could lead to an unintended consequence of decreasing the number of participating eligible professionals in 2010.

Response: We understand the concern posed by the commenters. We make every effort to increase the likelihood of successful data submission to PQRI on behalf of eligible professionals from qualified registries. While we cannot guarantee that a qualified registry will be able to send the quality measure data on behalf of their eligible professionals, a thorough vetting process has been established in order to qualify new registries. Part of this process includes determining the success of the 2009 PQRI registries with respect to their data submission. As in 2009, we are again requiring a self-nomination process for registries wishing to submit quality measures results and numerator and denominator data on 2010 PQRI quality measures or measure groups on behalf of eligible professionals for services furnished during the applicable reporting periods in 2010. Similar to previous years, the 2010 PQRI registry self-nomination process is based on a registry meeting specific technical and other requirements. While we strive to announce the qualified 2010 registries in advance of our target date, the selection process to determine qualified registries for 2010 PQRI is time-consuming. We anticipate posting the complete list of qualified 2010 registries as soon as we have completed vetting the registries interested in participating in the 2010 PQRI and identified the qualified registries for the 2010 PQRI. We expect to post the qualified registries no later than Summer 2010. In an attempt to address the commenters' requests, however, we do intend to post the names of the successful 2008 registries who intend to continue their participation in the 2010 PQRI. As stated in the CY 2010 PFS proposed rule (74 FR 33562 through 33563), this initial list of 2010 qualified registries will be available on the Web site by no later than December 31, 2009.

Comment: One commenter suggested we consider implementing a registry submission process that allows registries to demonstrate the recording and feedback of quality information, rather than go through a cumbersome method to transform the data for submission to CMS. The commenter noted that the current registry requirements appear to be designed in a way that would allow registry data to be transformed to claims data.

Response: We believe the commenter is reacting to the fact that the PQRI originated as a claims-based quality reporting program and he or she believes that registry requirements are still being designed to allow registry data to be transformed to claims data. We do not require registries to transform the quality data that they collect into a claims data format, as such a requirement would be overly prescriptive. In accordance with the registry qualifications set forth in section II.G.2.d.4. of this final rule with comment period, registries may collect and analyze data on PQRI measures and measures groups on behalf of eligible professionals pursuing incentive payment for the 2010 PQRI in any manner they deem appropriate for successful business operations. Therefore, an eligible professional who chooses registry-based reporting must submit data on PQRI quality measures or measures groups in whatever manner that is required by his or her selected qualified registry.

Comment: A commenter suggested that individual eligible professionals and small practices be offered a mechanism by which registry data could be cross-referenced with claims data to see if any other provider has supplied the appropriate care. The commenter remarked that this would allow eligible professionals to participate in registry-based reporting even if they do not have access to the quality information needed to report.

Response: The PQRI does not allow for one eligible professional's data to be ''cross-referenced'' with other eligible professional's data at the individual eligible professional level. This is however, consistent with one of the benefits of the physician group option

method of PQRI reporting, which will start in 2010 and is discussed in further detail in section II.G.2.g. of this final rule with comment period. Satisfactory participation in PQRI for individuals looks at reporting rates at the individual TIN/NPI level.

As a result of the comments, we are finalizing the requirements for individual eligible professionals who choose the registry-based reporting mechanism as proposed (74 FR 33562 through 33563) and discussed above.

We will post on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov* a list of qualified registries for the 2010 PQRI, including the registry name, contact information, and the 2010 measure(s) and/or measures group(s) for which the registry is qualified and intends to report. As proposed in the CY 2010 PFS proposed rule (74 FR 33562 through 33563), we will post the names of 2010 PQRI qualified registries in 2 phases. In either event, even though a registry is listed as ''qualified,'' we cannot guarantee or assume responsibility for the registry's successful submission of PQRI quality measures results and numerator and denominator data on PQRI quality measures or measures groups on behalf of eligible professionals.

In the first phase, we will post, by December 31, 2009, a list of those registries qualified for the 2010 PQRI based on: (1) Being a qualified registry for the 2008 and 2009 PQRI that successfully submitted 2008 PQRI quality measures results and numerator and denominator data on the quality measures; (2) having received a letter indicating their continued interest in being a PQRI registry for 2010; and (3) the registry's compliance with the 2010 PQRI registry requirements. By posting this first list of qualified registries for the 2010 PQRI, we seek to make available the names of registries that can be qualified at the start of the 2010 reporting period.

In the second phase, we will complete posting of the list of qualified 2010 registries as soon as we have completed vetting the additional registries interested in participating in the 2010 PQRI and identified the qualified registries for the 2010 PQRI, which we anticipate will be completed by no later than Summer 2010. An eligible professional's ability to report PQRI quality measures results and numerator and denominator data on PQRI quality measures or measures groups using the registry-based reporting mechanism should not be impacted by the complete list of qualified registries for the 2010 PQRI being made available after the start of the reporting period. First, registries will not begin submitting eligible professionals' PQRI quality measures results and numerator and denominator data on the quality measures or measures groups to CMS until 2011. Second, if an eligible professional decides that he or she is no longer interested in submitting quality measures results and numerator and denominator data on PQRI individual quality measures or measures group through the registry-based reporting mechanism after the complete list of qualified registries becomes available, this does not preclude the eligible professional from attempting to meet the criteria for satisfactory reporting through another 2010 PQRI reporting mechanism.

The process and requirements that will be used to determine whether a registry is qualified to submit quality measures results and numerator data on PQRI quality measures or measures groups on an eligible professional's behalf in 2010 are described in section II.G.2.d.4. of this final rule with comment period.

(3) Requirements for Individual Eligible Professionals Who Choose the EHR-Based Reporting Mechanism

For eligible professionals who choose to participate in the 2010 PQRI by submitting data on individual quality measures through the EHR-based reporting mechanism, the requirements we proposed associated with EHR-based reporting other than meeting the criteria for satisfactory reporting of individual measures were to: (1) select a qualified EHR product and (2) submit clinical quality data extracted from the EHR to a CMS clinical data warehouse (74 FR 33563). Provided that our 2009 EHR data submission testing process is successful, we proposed to begin accepting submission of clinical quality data extracted from ''qualified'' EHRs on January 1, 2010, or as soon thereafter as is technically feasible. We proposed that eligible professionals will have until March 31, 2011, to complete data submission through qualified EHRs for services furnished during the 2010 PQRI reporting period.

We did not propose any option to report measures groups through EHR-based reporting on services furnished during 2010. Because EHR-based reporting to CMS of data on quality measures would be new to PQRI for 2010, we proposed, for EHR-based reporting, to make available only the criteria applicable to reporting of individual PQRI measures. The criteria applicable to reporting of measures groups were not proposed to be available for EHR-based reporting for 2010.

The following is a summary of the comments we received regarding the proposed requirements for individual eligible professionals who choose the EHR-based reporting mechanism.

Comment: Some commenters urged CMS to conduct extensive education and outreach prior to implementation of EHR reporting for PQRI.

Response: We agree that it is necessary to educate eligible professionals regarding this new reporting mechanism prior to implementation. We anticipate doing so through PQRI National Provider Calls, or other CMS-sponsored calls, and through educational materials to be posted on the PQRI section of CMS Web site once qualified EHR vendors have been identified for the 2010 PQRI.

Comment: One commenter noted his or her expectation that the 2009 EHR Testing Program would be a success. Another commenter suggested we include a discussion of the 2009 EHR submission testing experience in this final rule.

Response: We appreciate the positive comment and anticipate the ongoing 2009 EHR data submission testing process will be a success. However, we have not completed the final beta test as of the writing of this final rule with comment period and therefore, we are unable to discuss the results of the testing process in this final rule with comment period.

Comment: Many commenters supported further expanding reporting mechanisms and moving forward with accepting quality measures data through EHRs for the PQRI program. Several commenters were pleased with our proposal to accept PQRI quality measure data extracted from qualified EHRs in 2010 and one commenter urged us to quickly finalize testing for the EHR-based reporting mechanism and allow participation in 2010 PQRI through the use of qualified EHRs. One commenter indicated the use of EHR data submission will result in the reporting of more robust quality measures.

Response: We encourage the adoption and use of EHRs and are appreciative of the commenters' support. We believe EHR-based reporting will enhance the quality of PQRI data reported by eligible professionals participating in the PQRI program and, compared to claims-based reporting, will relieve some of the reporting burden on eligible professionals.

Comment: One commenter remarked that all eligible professionals should have the option to report measures through an EHR. Similarly, another

commenter indicated opposition to the decision to limit EHR based reporting initially to a narrow subset of the universe of approved quality measures.

Response: We have selected 10 measures which can be reported from an EHR in this initial phase of quality data reporting from EHRs for PQRI. As we gain experience accepting quality measures data electronically, we will evaluate the feasibility of expanding the list of measures for which we have this capability.

Comment: A commenter suggested we allow hospital EHR systems to qualify as a reporting method for PQRI, as some eligible professionals are employed in a hospital facility which may be using an EHR (for example, Registered Dietitians).

Response: To the extent that a hospital utilizes an EHR system that is ''qualified'' for the 2010 PQRI, eligible professionals employed by the hospital can participate in the 2010 PQRI by submitting PQRI quality measures data extracted from the hospital's EHR system. We do not place restrictions on who can self-nominate to have one or more of their EHR products become qualified PQRI EHR products as long as the vendor successfully completes the self-nomination process described in section II.G.2.d.5. of this final rule with comment period.

Comment: One commenter concurred that we cannot assume responsibility for the successful submission of data from an eligible professional's EHRs.

Response: As discussed in the proposed rule (74 FR 33563), we cannot assume responsibility for the successful submission of data from any eligible professional's EHR. It is each EHR vendor's responsibility to ensure that it has updated its EHR product(s) to facilitate PQRI quality measures data submission.

Comment: One commenter recommended a more streamlined approach to simplify the reporting criteria and time-periods for EHR users, by allowing EHR users to report on all their patients throughout the year.

Response: For satisfactory PQRI reporting via a qualified EHR, we are requiring all PQRI quality data to be submitted at one time. This will allow us to finish the infrastructure development and will also allow CMS and eligible professionals to avoid redundant reporting by inadvertently submitting data previously reported. Also, we believe one-time reporting is more convenient for eligible professionals.

Comment: One commenter commended CMS for acknowledging the Health Information Technology for Economic and Clinical Health (HITECH) Act and its focus on EHR implementation for incentive payments, meaningful use, and quality reporting. Some commenters suggested that we align initiatives in response to the health information technology (HIT) incentives and with applicable provisions in the HITECH Act regarding EHR certification requirements (that is, HITECH requires eligible professionals to use certified technology) so that eligible professionals can follow similar qualification and/or certification requirements as they prepare for quality reporting for both PQRI and the HITECH Act incentive programs. Another commenter remarked that EHR systems may require reinstallation or significant maintenance/upgrades to meet ''meaningful use'' criteria, which could potentially take months to achieve. Coordinating reporting standards may help minimize preparation and reporting requirements for program participants. Another commenter suggested we advocate to the Certification Commission of Health Information Technology for the inclusion of PQRI reporting capabilities in the certification criteria.

Response: Any EHR quality data submission will be required to comply with all current regulations regarding security and privacy. ''Meaningful use'' criteria will be reviewed as they are finalized and we will endeavor to align our work in the future, as appropriate. However, since meaningful use criteria have not yet been finalized, this comment is currently beyond the scope of this final rule with comment period.

Comment: One commenter remarked that an EHR is a tool that allows physicians to improve work flow and efficiency by electronically documenting data, however it does not, in all cases, have a quality feedback loop for providers. One commenter recommended that we provide back to the submitter, feedback on the extracted data that is received and then that feedback should be provided back to the eligible professional. The commenter also suggested we require that this process include return receipt for the data content prior to scoring for PQRI participation and calculation of incentive payment.

Response: With regard to a ''feedback loop,'' we note that the EHR data submission process is such that the eligible professional will know if the file he or she sent to us has been successfully submitted and accepted. A file which is not accepted will be returned with an error code. We note, however, that successful submission of a data file does not indicate that the eligible professional met the criteria for satisfactory reporting; it just indicates that we received the data file that was sent to us.

As is the case for other eligible professionals participating in PQRI, eligible professionals submitting their quality data through an EHR will receive a feedback report from us that will be accessible in the same manner as other feedback reports we provide for other reporting mechanisms.

As a result of the comments and our experience thus far with the ongoing 2009 EHR Testing Program, eligible professionals who choose the EHR-based reporting mechanism for the 2010 PQRI will be required to (in addition to meeting the criteria for satisfactory reporting of individual measures):

- Have a qualified EHR product;
- Have an active IACS user account that will be used to submit clinical quality data extracted from the EHR to a CMS clinical data warehouse;
- Submit a test file containing real or dummy clinical quality data extracted from the EHR to a CMS clinical data warehouse via IACS between July 1, 2010 and September 30, 2010 (if technically feasible); and
- Submit a file containing the eligible professional's 2010 PQRI clinical quality data extracted from the EHR for the entire reporting period (that is January 1, 2010 through December 31, 2010) via IACS between January 1, 2011 through February 28, 2011.

As stated above, however, the 2009 EHR Testing Program is still ongoing. Since only EHR vendors that self-nominated to participate in the 2009 EHR Testing Program and successfully complete the 2009 EHR Testing Program will be considered qualified EHR vendors for the 2010 PQRI, there is no guarantee that there will be any qualified EHR vendors available for the 2010 PQRI. In addition, as we complete the 2009 EHR Testing Program and are better able to determine what is technically feasible, the actual dates on which eligible professionals are required to submit their test files and/or to begin submitting the actual 2010 PQRI data are subject to change.

As stated above, we also cannot assume responsibility for the successful submission of data from eligible professionals' EHRs. Any eligible professional who chooses to submit PQRI data extracted from an EHR should contact the EHR product's vendor to determine if the product is qualified and has been updated to facilitate PQRI quality measures data submission. Such professionals also should begin attempting submission soon after the opening of the clinical

data warehouse in order to assure the professional has a reasonable period of time to work with his or her EHR and/or its vendor to correct any problems that may complicate or preclude successful quality measures data submission through that EHR. As we indicated above, data submission for the 2010 PQRI will need to be completed by February 28, 2011.

The specifications for the electronic transmission of the 2010 PQRI measures identified in Table 14 of this final rule as being available for EHR-based reporting in 2010 are posted on Alternative Reporting Mechanisms page of the PQRI section of the CMS Web site.

(4) Qualification Requirements for Registries

For the 2010 PQRI, we proposed to require a self-nomination process for registries wishing to submit 2010 PQRI quality measures or measures groups on behalf of eligible professionals for services furnished during the applicable reporting periods in 2010 (74 FR 33563). The proposed registry self-nomination process for the 2010 PQRI would be based on a registry meeting specific technical and other requirements.

To be considered a qualified registry for purposes of submitting individual quality measures and measures groups on behalf of eligible professionals who choose to report using this reporting mechanism under the 2010 PQRI, we proposed that a registry would need to:

- Be in existence as of January 1, 2009;
- Be able to collect all needed data elements and calculate results for at least 3 measures in the 2010 PQRI program (according to the posted 2010 PQRI Measure Specifications);
- Be able to calculate and submit measure-level reporting rates by TIN/NPI;
- Be able to calculate and submit, by TIN/NPI, a performance rate (that is, the percentage of a defined population who receive a particular process of care or achieve a particular outcome) for each measure on which the TIN/NPI reports;
- Be able to separate out and report on Medicare Part B FFS patients;
- Provide the name of the registry;
- Provide the reporting period start date the registry will cover;
- Provide the reporting period end date the registry will cover;
- Provide the measure numbers for the PQRI quality measures on which the registry is reporting;
- Provide the measure title for the PQRI quality measures on which the registry is reporting;
- Report the number of eligible instances (reporting denominator);
- Report the number of instances of quality service performed (numerator);
- Report the number of performance exclusions;
- Report the number of reported instances, performance not met (eligible professional receives credit for reporting, not for performance);
- Be able to transmit this data in a CMS-approved XML format. We expect that this CMS-specified record layout will be substantially the same as for the 2008 and 2009 PQRI. This layout will be provided to registries in 2010;
- Comply with a CMS-specified secure method for data submission, such as submitting its data in an XML file through an IACS user account;
- Submit an acceptable ''validation strategy'' to CMS by March 31, 2010. A validation strategy ascertains whether eligible professionals have submitted accurately and on at least the minimum number (80 percent) of their eligible patients, visits, procedures, or episodes for a given measure. Acceptable validation strategies often include such provisions as the registry being able to conduct random sampling of their participants' data, but may also be based on other credible means of verifying the accuracy of data content and completeness of reporting or adherence to a required sampling method;
- Enter into and maintain with its participating professionals an appropriate Business Associate agreement that provides for the registry's receipt of patient-specific data from the eligible professionals, as well as the registry's disclosure of quality measure results and numerator and denominator data on behalf of eligible professionals who wish to participate in the PQRI program;
- Obtain and keep on file signed documentation that each holder of an NPI whose data are submitted to the registry has authorized the registry to submit quality measures results and numerator and denominator data to CMS for the purpose of PQRI participation. This documentation must be obtained at the time the eligible professional signs up with the registry to submit PQRI quality measures data to the registry and must meet any applicable laws, regulations, and contractual business associate agreements;
- Provide CMS access (if requested) to review the Medicare beneficiary data on which 2010 PQRI registry-based submissions are founded;
- Provide the reporting option (reporting period and reporting criteria) that the eligible professional has satisfied or chosen; and
- Provide CMS a signed, written attestation statement via mail or e-mail which states that the quality measure results and numerator and denominator data provided to CMS are accurate and complete (74 FR 33563 through 33564).

With respect to the submission of 2010 measure results and numerator and denominator data on measures groups, we proposed to retain in 2010 the following registry requirements from the 2009 PQRI:

- Indicate the reporting period chosen for each eligible professional who chooses to submit data on measures groups;
- Base reported information on measures groups only on patients to whom services were furnished during the 12-month reporting period of January through December 2010 or the 6-month reporting period of July 2010 through December 2010;
- Agree that the registry's data may be inspected by CMS under our oversight authority if non-Medicare patients are included in the patient sample;
- Be able to report data on all of the measures in a given measures group and on either 30 patients from January 1 through December 31, 2010 (note this patient sample must include some Medicare Part B FFS beneficiaries) or on 80 percent of applicable Medicare Part B FFS patients for each eligible professional (with a minimum of 15 patients during the January 1, 2010 through December 31, 2010 reporting period or a minimum of 8 patients during the July 1, 2010 through December 31, 2010 reporting period); and
- Be able to report the number of Medicare FFS patients and the number of Medicare Advantage patients that are included in the patient sample for a given measures group (74 FR 33564).

In addition to the above requirements, we proposed the following new requirements for registries for the 2010 PQRI:

- Registries must have at least 25 participants;
- Registries must provide at least 1 feedback report per year to participating eligible professionals;
- Registries must not be owned and managed by an individual locally-owned single-specialty group (in other words, single-specialty practices with only 1 practice location or solo practitioner practices would be prohibited from self-nominating to become a qualified PQRI registry);
- Registries must participate in ongoing 2010 PQRI mandatory support conference calls hosted by CMS

(approximately 1 call per month), including an in-person registry kick-off meeting to be held at CMS headquarters in Baltimore, MD;

• Registries must provide a flow and XML of a measure's calculation process for each measure type that the registry intends to calculate; and

• Registries must use PQRI measure specifications to calculate reporting or performance unless otherwise stated (74 FR 33654).

The following is summary of the comments we received regarding the proposed qualification requirements and self-nomination process for registries for the 2010 PQRI.

Comment: We received several comments supporting many of the proposed qualification requirements for registries. A number of commenters agreed with the proposed requirement that registries must have a minimum of 25 participants. Similarly, one commenter remarked that the rationale for restricting a single practice site or solo practitioners from becoming a qualified registry is unclear and suggested that such entities should not be prohibited from becoming a qualified registry if they otherwise meet the requirements.

Response: We appreciate the supportive comments and believe that the additional requirements will improve registry based reporting. We limited registry participation to registries with at least 25 participants to conserve both CMS and eligible professionals' resources. Every registry goes through a vetting process which includes providing a sample measure flow illustrating how that registry will calculate an example of each type of measure it plans to submit to CMS. Additionally, registries must send in a sample XML file per the CMS specifications. This process occurs over a 2–3 month period and requires resources on the part of CMS, as well as the potential registry. Finally, a mandatory in-person registry kick-off meeting is held each year at CMS headquarters in Baltimore, MD. We believe the time and expense for a solo practitioner or single practice site to go through these steps would be prohibitive for most practitioners or practice sites. We do not believe that a majority of solo practitioners or single practice sites do not have the information technology (IT) staffing and resources needed to successfully complete the vetting process. Furthermore, we do not have the resources to provide IT support to such entities.

Comment: Numerous commenters strongly supported the requirement for registries to provide at least one feedback report per year to participating eligible professionals. Several commenters suggested the feedback reports from registries be issued to eligible professionals at some point during the reporting year so as to allow practices to assess their performance both on reporting and on performance, which may inform and promote internal quality improvement. One commenter stated providing eligible professionals with access to feedback reports during the reporting year would allow more accurate assessment of their performance before the close of the reporting period.

Response: We agree that the requirement for registries to provide at least one feedback report per year is an essential tool for quality improvement and must be provided to participating eligible professionals. The information contained within feedback reports will allow the eligible professional to assess the quality of care they provided to their patients during the specific reporting timeframe of the report. Furthermore the report may provide information for the promotion of internal quality improvement. While we will not require registries to provide more than the minimum number of feedback reports per year (one) to participating eligible professionals, we would be supportive of such a decision by a registry.

Comment: One commenter recommended we develop an audit program for registry vendors, as the PQRI program moves away from claims-based reporting. The commenter suggested eligible professionals participating in the PQRI look to CMS for assurance that registry vendors are regularly inspected for quality.

Response: As we gain more experience with registry submission, we would expect to further specify through rulemaking qualification requirements for registries that may include more comprehensive validation requirements. As we evaluate our policies, we plan to continue a dialogue with stakeholders to discuss opportunities for program efficiency and flexibility.

As a result of the comments, we are finalizing the 2010 qualification requirements for registries as proposed (74 FR 33563 through 33565).

We will post the 2010 PQRI registry requirements, including the exact date by which registries that wish to qualify for 2010 must submit a self-nomination letter and instructions for submitting the self-nomination letter, on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* by November 15, 2009. We anticipate that new registries that wish to self-nominate for 2010 will be required to do so by January 31, 2010.

We are finalizing our proposal (74 FR 33563 through 33565) that registries that were ''qualified'' for 2009 and wish to continue to participate in 2010 will not need to be ''re-qualified'' for 2010 unless they are unsuccessful at submitting 2009 PQRI data (that is, fail to submit 2009 PQRI data per the 2009 PQRI registry requirements). Registries that are ''qualified'' for 2009 and wish to continue to participate in 2010 were required to indicate their desire to continue participation for 2010 by submitting a letter to CMS indicating their continued interest in being a PQRI registry for 2010 and their compliance with the 2010 PQRI registry requirements by no later than October 31, 2009. Instructions regarding the procedures for submitting this letter were provided to qualified 2009 PQRI registries on the 2009 PQRI registry support conference calls.

If a qualified 2009 PQRI registry fails to submit 2009 PQRI data per the 2009 PQRI registry requirements, the registry will be considered unsuccessful at submitting 2009 PQRI data and will need to go through the full self-nomination process again to participate in the 2010 PQRI. By March 31, 2010, registries that are unsuccessful submitting quality measures results and numerator and denominator data for 2009 will need to be able to meet the 2010 PQRI registry requirements and go through the full vetting process again.

As stated in the proposed rule, the above registry requirements will apply not only for the purpose of a registry qualifying to report 2010 PQRI quality measure results and numerator and denominator data on PQRI individual quality measures or measures groups, but also for the purpose of a registry qualifying to submit the proposed electronic prescribing measure for the 2010 E-Prescribing Incentive Program (see section II.G.5. of this final rule with comment period.

(5) Qualification Requirements for EHR Vendors and Their Products

As stated in the proposed rule (74 FR 33565), we proposed that EHR products listed on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* as a ''qualified'' EHR product (that is, the name of the vendor software product and the version that is qualified), would be available for the product's users to submit quality data to CMS directly from their system for the 2010 PQRI. We also proposed that we would post this list of qualified EHR vendors and products upon completion of the 2009 EHR Testing Program. We

anticipate the 2009 EHR Testing Program will be complete in early 2010.

Vendors' EHR products that are listed as ''qualified'' products were selected because the vendor self-nominated to participate in the 2009 EHR Testing Program and demonstrated that their products met the ''Requirements for Electronic Health Record (EHR) Vendors to Participate in the 2009 PQRI EHR Testing Program'' that were posted on the Alternative Reporting Mechanisms page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage* on December 31, 2008. Additionally, a vendor's EHR system must be updated according to the Draft 2010 EHR specifications posted on the Alternative Reporting Mechanisms page of the PQRI section of the CMS Web site in order for an EHR vendor and its product to be qualified to submit information on 2010 PQRI measures.

As stated in the proposed rule (74 FR 33565), we proposed that the EHR vendor requirements described above would apply not only for the purpose of a vendor's EHR product being qualified for the purpose of the product's users being able to submit data extracted from the EHR for the 2010 PQRI, but also for the purpose of a vendor's EHR product being qualified for the purpose of the product's users being able to electronically submit data extracted from the EHR for the electronic prescribing measure for the 2010 E-Prescribing Incentive Program.

The following is a summary of the comments received regarding the proposed 2010 EHR vendor qualification requirements and/or process.

Comment: One commenter recommended we implement an ongoing qualification process for new vendors and systems to enable inclusion of vendors that did not self-nominate or did not exist prior to the reporting year.

Response: Currently there is an ongoing qualification process for new EHR vendors and their products. EHR vendors interested in enabling their customers to submit data on PQRI that is extracted from their customers' EHRs must complete the EHR vendor quality data submission qualification process to be considered. For the 2010 PQRI, we will consider those EHR vendors who successfully completed the 2009 EHR Testing Program to be qualified for purposes of the 2010 PQRI. We will list the vendors qualified for the 2010 PQRI on the PQRI section of the CMS Web site upon completion of the 2009 PQRI EHR Testing Process. We anticipate completing the 2009 PQRI EHR Testing Process in early 2010.

During 2010, we expect to use a similar self-nomination process described in the ''Requirements for Electronic Heath Record (EHR) Vendors to Participate in the 2009 PQRI EHR Testing Program'' posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage* to qualify additional vendors for the 2011 PQRI. This document is subject to modification for the 2011 EHR self-nomination process. In any case, a vendor must self-nominate no later than January 31, 2010 to be eligible to participate in the 2011 PQRI Testing Process in 2010. Sometime in 2010, those EHR products that meet all of the EHR vendor requirements will be listed on the PQRI section page of the CMS Web site at *http://www.cms.hhs.gov/PQRI* as a ''qualified'' EHR product, which indicates that the vendor's product's users may submit quality data to CMS for the 2011 PQRI or subsequent years.

Comment: Some commenters commended the establishment of electronic standards for EHR-based reporting.

Response: We appreciate the supportive comments regarding the establishment of standard qualification requirements for EHR reporting.

Comment: A few of commenters expressed concern regarding the criteria set forth to rigidly define ''qualified'' EHRs. These concerns stem from the fact that some EHR products are developed for health care professionals specific to their needs (such as physical therapists, oncologists, etc.). Another commenter remarked that vendors for specialty-specific EHR products, such as oncology-specific EHR products, should not have to adjust their software to comply with certification procedures designed for a general ambulatory system. This commenter stated that the goal of EHRs should be to contain comprehensive information relevant to each patient's condition, their treatment plan and outcomes, but in some cases, specific terminology and data collection to support the eligible professional.

Response: We recognize that some EHR products have been designed to accommodate specific specialties, however, we are unclear how this would prevent the EHR product from meeting the EHR qualification requirements other than that there are no measures available for reporting via EHR. As we analyze the EHR reporting mechanism for 2010, we will consider expanding the measures available for electronic submission in the future.

Comment: One commenter recommended that we develop an audit program for EHR vendors, as the PQRI moves away from claims-based reporting. The commenter suggested eligible professionals participating in the PQRI look to CMS for assurance that vendors are regularly inspected for quality.

Response: Ensuring that vendors meet and perform properly would fall under the purview of their certifying body, which is currently CCHIT (if the product is CCHIT certified). During the qualification process (in which we conduct testing to ensure that the EHR can extract and transmit the necessary quality data elements), we evaluate the vendor and their program to see if the system is capable of performing the necessary tasks required for quality reporting to us for PQRI.

Comment: One commenter noted that some practitioners do not have authority under state law to prescribe medications, and thus products developed to meet the needs of these eligible professionals need not incorporate electronic prescribing functionality at this time.

Response: We recognize the concerns cited by the commenter and note that PQRI does not require qualified EHRs to have an electronic prescribing module in order for eligible professionals to participate in the PQRI via a qualified EHR. We believe the commenter is referring to the idea of ''meaningful use'' with respect to requiring an electronic prescribing module in the EHR system for purposes of the HITECH Act incentive programs. The issue of ''meaningful use'' is beyond the scope of this rule.

As previously stated above, only EHR vendors that self-nominated to participate in the 2009 EHR Testing Program and successfully complete the 2009 EHR Testing Program will be considered qualified EHR vendors for the 2010 PQRI. There is no guarantee that there will be any qualified EHR vendors available for the 2010 PQRI since the 2009 EHR Testing Program is still ongoing.

During 2010, we expect to use the self-nomination process described in the ''Requirements for Electronic Health Record (EHR) Vendors to Participate in the 2009 PQRI EHR Testing Program'' posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/20_AlternativeReporting Mechanisms.asp#TopOfPage,* to qualify additional EHR vendors and their EHR products to submit quality data extracted from their EHR products to the CMS clinical quality data warehouse for program years after 2010. We anticipate that the requirements will be similar to those used to qualify EHR products for

the 2009 PQRI EHR Testing Program, but they may be modified based on the results of our 2009 EHR testing. Any updates to the EHR vendor requirements, which would be based on our experience with the 2009 EHR Testing Program and would be non-substantive in nature, will be made December 15, 2009, and will be posted on the PQRI section of CMS Web site at *http://www.cms.hhs.gov/PQRI.* As stated previously, any EHR vendor interested in having one or more of their EHR products ''qualified'' to submit quality data extracted from their EHR products to the CMS clinical quality data warehouse for 2011 and subsequent years must submit their self-nomination letter by January 31, 2010. Instructions for submitting the self-nomination letter will be provided in the 2011 EHR vendor requirements. At the conclusion of this process, those EHR products that meet all of the EHR vendor requirements will be listed on the PQRI section of the CMS Web site as a ''qualified'' EHR product, which indicates that the product's users may submit quality data to CMS for the 2011 PQRI or subsequent years.

e. Criteria for Satisfactory Reporting of Individual Quality Measures for Individual Eligible Professionals

As discussed in the proposed rule (74 33565 through 33568), for years after 2009, section 1848(m)(3)(D) of the Act authorizes the Secretary, in consultation with stakeholders and experts, to revise the criteria for satisfactorily reporting data on quality measures. Based on this authority and the input we have received from stakeholders via the invitation to submit suggestions for the 2010 PQRI reporting options posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* in April 2009, we proposed 3 criteria for satisfactory reporting of individual PQRI quality measures for 2010. In an effort to continue to be consistent with the criteria of satisfactory reporting used in prior PQRI program years, we proposed to retain the following 2 criteria with respect to satisfactorily reporting data on individual quality measures in circumstances where 3 or more individual quality measures apply to the services furnished by an eligible professional:

- Report on at least 3 2010 PQRI measures; and
- Report each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

These criteria would apply to all 2010 PQRI reporting mechanisms available for reporting individual PQRI quality measures.

If an eligible professional has fewer than 3 PQRI measures that apply to the professional's services, then the professional would be able to meet the criteria for satisfactorily reporting data on individual quality measures by meeting the following 2 criteria:

- Reporting on all measures that apply to the services furnished by the professional (that is 1 to 2 measures); and
- Reporting each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

We proposed that, as in previous years, these criteria for satisfactorily reporting data on fewer than 3 individual quality measures would be available for the claims-based reporting mechanism only. An eligible professional who has fewer than 3 PQRI measures that apply to the professional's services would not be able to meet the criteria for satisfactory reporting by reporting on all applicable measures (that is, 1 or 2 measures) through the registry-based or EHR-based reporting mechanisms.

We also proposed that an eligible professional who reports on fewer than 3 measures through the claims-based reporting mechanism in 2010 may be subject to the Measure Applicability Validation (MAV) process, which allows us to determine whether an eligible professional should have reported quality data codes for additional measures. When an eligible professional reports on fewer than 3 measures, we proposed to review whether there are other closely related measures (such as those that share a common diagnosis or those that are representative of services typically provided by a particular type of professional). If an eligible professional who reports on fewer than 3 measures in 2010 reports on a measure that is part of an identified cluster of closely related measures and did not report on any other measure that is part of that identified cluster of closely related measures, then the professional would not qualify to receive a 2010 PQRI incentive payment. Additional information on the MAV process can be found on the Analysis and Payment page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.*

In addition to the above criteria related to the number of measures on which an eligible professional would be required to report and the frequency of reporting, we proposed a third criterion for satisfactory reporting of individual measures. Based on our authority to revise the criteria for satisfactory reporting under section 1848(m)(3)(D) of the Act, we proposed (74 FR 33566) that an eligible professional also be required to report data on at least one individual measure on a minimum number of Medicare Part B FFS patients seen during the reporting period, as detailed below.

Regardless of the reporting mechanism chosen by the eligible professional, we proposed (74 FR 33567) that the minimum patient sample size for reporting individual quality measures be 15 Medicare Part B FFS patients for the 12-month reporting period. An eligible professional would need to meet this minimum patient sample size requirement for at least one measure on which the eligible professional chooses to report. Similarly, for the 6-month reporting period (which was proposed to be available for registry-based reporting only), we proposed that the minimum patient sample size for reporting on individual quality measures be 8 Medicare Part B FFS patients seen during the 6-month reporting period. An eligible professional would need to meet this minimum patient sample size requirement for at least one measure on which the eligible professional chooses to report.

We solicited comments on the proposal to add a minimum patient sample size criterion to the criteria for satisfactory reporting of data on individual quality measures. In addition, we solicited comments on the specific thresholds proposed for the 12-month reporting period (which was proposed to be available for claims-based, registry-based, and EHR-based reporting) and for the 6-month reporting period (which was proposed to be available for registry-based reporting only) for reporting individual quality measures.

The following is summary of the comments we received regarding the criteria for satisfactory reporting of individual quality measures for individual eligible professionals.

Comment: We received several comments supporting the proposed minimum patient sample size requirement for PQRI reporting of individual measures (that is, at least 15 patients for at least 1 measure for the 12-month reporting period and at least 8 patients for at least 1 measure for the 6-month reporting period). A few commenters supported the proposed minimum patient sample requirement

only if eligible professionals are required to meet the proposed threshold(s) for only 1 measure on which they report. Many commenters remarked that the minimum patient sample size requirement would encourage eligible professionals to select more applicable measures while discouraging eligible professionals from selectively reporting measures that are not representative of the types of services they normally provide in their practice. The commenters also remarked that the minimum sample size requirements will enhance the scientific validity of eligible professionals' performance results.

Response: We agree with the reasons cited by commenters for why the minimum patient sample size requirement is important. However, analysis of preliminary data from the 2008 PQRI indicates that a significant number of eligible professionals who would otherwise meet the criteria for satisfactory reporting would be adversely impacted by the addition of a minimum patient sample size requirement to the criteria for satisfactory reporting of individual measures by individual eligible professionals. Therefore, we are not finalizing the proposed minimum patient sample requirement. We will reconsider adding a minimum patient sample requirement to the criteria for satisfactory reporting of individual measures for future years upon further analysis of the PQRI data.

Comment: We also received comments requesting that we withdraw the proposed minimum patient sample requirement. The commenters were concerned that this requirement would create a participation barrier for certain eligible professionals, such as those who treat patients with rare conditions, those with small practices, and/or those with relatively few Medicare patients.

Response: For the reasons stated above and based on the commenters' concerns that such a requirement would create participation barriers for certain eligible professionals, we are not finalizing the proposed minimum patient sample size requirement for the PQRI reporting options for individual measures reporting. However, upon further analysis of the PQRI data, we will reconsider adding a minimum patient sample requirement to the criteria for satisfactory reporting of individual measures and explore other means of enhancing the PQRI criteria for satisfactory reporting for future years.

Comment: A majority of commenters believed that the proposed minimum patient sample size thresholds were appropriate. Some commenters, however, believed that the thresholds should be lowered to 10 or 15 for the 12-month reporting period and 6 for the 6-month reporting period. Other commenters believed that the thresholds should be higher, such as 25 or 30 for the 12-month reporting period.

Response: As stated previously, we are not finalizing the proposed minimum patient sample size requirement for reporting of 2010 PQRI individual measures. As we reassess this requirement for future years, we anticipate that we will continue to monitor the PQRI data on an ongoing basis and reassess the thresholds as needed for future years.

Comment: One commenter suggested that we reconsider allowing registry-based reporting for fewer than 3 measures, primarily to encourage eligible professionals to transition to registry-based reporting, as the claims-based option becomes phased out. This option may also allow greater flexibility for the program.

Response: We appreciate the intent of this comment, however, as in previous years, satisfactorily reporting data on fewer than 3 individual quality measures will only be available for the claims-based reporting mechanism. While we have received similar comments in the past, we continue to believe that permitting an eligible professional to report fewer than 3 measures through the registry-based reporting mechanism, (if fewer than 3 measures apply to him or her) would be inefficient at this time. Analytically it would be difficult to implement in that if an eligible professional submits fewer than 3 measures via registries, we would not know whether the eligible professional did so because only 2 measures applied to him or her or because the registry only accepts data for 2 of the provider's measures and he or she is reporting their third measure via claims. We also look for the most favorable method of reporting (that is, did the eligible professional report via a different method for a longer reporting period as well as whether an eligible professional satisfactorily reported under a different reporting option if he or she did not satisfactorily report for a particular reporting option). Accepting fewer than 3 measures from registries would increase the amount of cross-checking already required and makes it impractical to implement the commenter's suggestions at this time. Should the claims-based reporting mechanism be removed entirely from the PQRI program at some point in the future, we may revisit the issue of allowing registries to submit data for eligible professionals on fewer than 3 measures.

Comment: One commenter remarked that limiting EHR-based reporting to reporting on individual measures would limit the ability of some eligible professionals to report on the measures most relevant to them by eliminating one reporting mechanism (such as electronic reporting of the back pain measures for spine care).

Response: The EHR reporting mechanism for PQRI is still in an early development phase. This mechanism will be closely examined in the future, and may be expanded as appropriate. We believe that the first set of measures specified electronically have broad appeal in that they deal with common conditions such as diabetes and prevention.

Comment: Some commenters recommended significant changes to the criteria for satisfactory reporting that would not be consistent with the criteria for satisfactory reporting for prior years. For example, one commenter recommended that as the PQRI moves forward, the definition of satisfactory reporting should not be determined by what the commenter believed were somewhat arbitrary formulas but rather by accurate data that is able to reflect the ways in which a provider attempted to relay the quality of their patient care. Another commenter recommended that CMS phase out the existing process by which participating professionals select the measures on which they will be report. Instead CMS should assign each participating individual eligible professional with sets of measures for high volume conditions, based on services provided to their patient population. Similarly, another commenter recommended more criteria to guide measure selection by eligible professionals and that we require eligible professionals to report on 6 measures.

Response: We agree with commenters that as the PQRI matures, we will need to reassess the criteria for satisfactory reporting so that the information that we collect becomes more representative of the quality of care provided by eligible professionals. We also generally agree with the goals cited by the commenters, but have concerns that the specific suggestions offered by the commenters are not operationally practical and feasible when we take into account the vast numbers of eligible professionals and the diversity of their practices.

In addition, we believe that such significant changes should occur gradually. The criteria for satisfactory reporting are specifically defined under section 1848(m)(3)(A) of the Act. With

the authority under section 1848(m)(3)(D) of the Act to revise the criteria for satisfactory reporting for years after 2009, we have started to move towards the direction recommended by commenters with the introduction of the minimum patient sample size requirement for individual measures reporting for the 2010 PQRI. In addition, the new PQRI group practice reporting option also moves the PQRI towards the direction recommended by commenters in that we assign participating group practices both the measures and patients on which they are required to report. We will consider additional changes to the criteria for satisfactory reporting for 2011 and beyond and look forward to receiving stakeholder input on how we can revise the criteria for satisfactory reporting in an operationally practical and feasible manner to achieve the goals cited by commenters.

Comment: One comment was received with respect to the MAV, which allows us to determine whether an eligible professional should have reported quality data codes for additional measures when an eligible professional submits fewer than 3 individual PQRI measures. The commenter requested that CMS provide updates on newly identified clusters of closely related measures that will be employed in the MAV for 2010.

Response: No changes are planned for the MAV process for 2010. Additional information on the MAV process are listed on the Analysis and Payment page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.* However, we are contemplating some changes to the clusters of closely related measures based on the addition or removal of measures in the 2010 PQRI or the fact that certain measures included in these clusters will become registry-only measures for 2010. For example, if measures in an existing cluster are retired for the 2010 PQRI or are made registry-only then the cluster will be revised or deleted as appropriate.

Based on the new 2010 PQRI measures, the only new clusters being contemplated are a second preventive cluster, 2 new anesthesia care clusters, an ear care cluster, and an Ischemic Vascular (IVD) cluster. The second preventive cluster would consist of the following 2 measures: (1) Measure #114 Preventive Care and Screening: Inquiry Regarding Tobacco Use and (2) Measure #115 Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit. The first anesthesia care cluster would consist of 2 measures: (1) Measure #30 Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics and (2) Measure #76 Prevention of Catheter-Related Bloodstream Infections (CRBI): Central Venous Catheter (CVC) Insertion Protocol. The second anesthesia care cluster would consist of Measure #76 and the new Perioperative Temperature Management measure. For both of the anesthesia care clusters, however, the MAV would not apply if an eligible professional reports only Measure #76. Measure # 76 is a broadly applicable measure that encompasses services often provided by eligible professionals for whom Measure #30 and the Perioperative Temperature Management measure do not apply such as intensivists, hospitalists, internists, and emergency physicians. The ear care cluster would consist of the 3 new referral for otologic evaluation measures listed in Table 13 of this final rule. The IVD cluster would consist of the following 4 new PQRI measures:

- Ischemic Vascular Disease (IVD): Blood Pressure Management Control;
- Ischemic Vascular Disease (IVD): Complete Lipid Profile;
- Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL–C) Control; and
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Anti-Thrombotic.

By no later than December 31, 2009, we will post the final MAV process for 2010 and the final 2010 MAV clusters on the Analysis and Payment page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/25_AnalysisAndPayment.asp#TopOfPage.*

After considering the comments and the new 6-month reporting period for claims-based reporting of individual PQRI quality measures that we are adding to the 2010 PQRI at the request of commenters, the final 2010 criteria for satisfactory reporting of data on individual PQRI quality measures are summarized in Table 7 and are arranged by reporting mechanism and reporting period. The criteria for satisfactory reporting for claims-based reporting of individual PQRI quality measures for the 6-month reporting period are consistent with the criteria for satisfactory reporting of individual PQRI quality measures.

For the 2010 PQRI, there are a total of 5 reporting options, or ways, in which an eligible professional may meet the criteria for satisfactory reporting on individual quality measures. Each reporting option consists of the criteria for satisfactory reporting such data and results on individual quality measures relevant to a given reporting mechanism and reporting period. While eligible professionals may potentially qualify as satisfactorily reporting individual quality measures under more than one of the reporting criteria, reporting mechanisms, and/or for more than one reporting period, only one incentive payment will be made to an eligible professional based on the longest reporting period for which the eligible professional satisfactorily reports.

TABLE 7—2010 CRITERIA FOR SATISFACTORY REPORTING OF DATA ON INDIVIDUAL PQRI QUALITY MEASURES, BY REPORTING MECHANISM AND REPORTING PERIOD

Reporting mechanism	Reporting criteria	Reporting period
Claims-based reporting	• Report at least 3 PQRI measures, or 1–2 measures if less than 3 measures apply to the eligible professional; and • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies.	January 1, 2010–December 31, 2010.
Claims-based reporting	• Report at least 3 PQRI measures, or 1–2 measures if less than 3 measures apply to the eligible professional; and • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies.	July 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 3 PQRI measures; and	January 1, 2010–December 31, 2010.

TABLE 7—2010 CRITERIA FOR SATISFACTORY REPORTING OF DATA ON INDIVIDUAL PQRI QUALITY MEASURES, BY REPORTING MECHANISM AND REPORTING PERIOD—Continued

Reporting mechanism	Reporting criteria	Reporting period
	• Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies.	
Registry-based reporting	• Report at least 3 PQRI measures; and • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies.	July 1, 2010–December 31, 2010.
EHR-based reporting	• Report at least 3 PQRI measures; and • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies.	January 1, 2010–December 31, 2010.

f. Proposed Criteria for Satisfactory Reporting Measures Groups for Individual Eligible Professionals

For the 2010 PQRI, we proposed 2 basic sets of criteria for satisfactory reporting on a measures group (74 FR 33568). Both sets of criteria would apply to the claims-based and registry-based reporting mechanism. We did not propose to make the EHR-based reporting mechanism available for reporting on measures groups in 2010.

The first set of proposed criteria, which we proposed to make available for either the 12-month or 6-month reporting period in 2010, would be consistent with the 2009 criteria for satisfactory reporting of measures groups through registry-based reporting, which require the reporting of at least 1 measures group for at least 80 percent of patients to whom the measures group applies during the applicable reporting period (with reporting required on a minimum number of Medicare Part B FFS patients commensurate with the reporting period duration). In the 2009 PQRI, there was a requirement under these criteria to report each measures group on at least 30 Medicare Part B FFS patients for the 12-month reporting period and at least 15 Medicare Part B FFS patients for the 6-month reporting period for registry-based reporting of measures groups. For the 2010 PQRI, we proposed to revise the requirement by making these criteria applicable to both registry-based and claims-based reporting and to change the number of Medicare Part B FFS patients on which an eligible professional would be required to report a measures group. We proposed to require an eligible professional who chooses to report on measures groups based on reporting on 80 percent of applicable patients to report on a minimum of 15 Medicare Part B FFS patients for the 12-month reporting period and a minimum of 8 Medicare Part B FFS patients for the 6-month reporting period, regardless of whether the eligible professional chooses to report the measures group through claims-based reporting or registry-based reporting.

The second set of proposed criteria, which we proposed to make available for the 12-month reporting period only, would be based on reporting on a measures group on a specified minimum number of patients (74 FR 33568). The second set of criteria would require reporting on at least 1 measures group for at least 30 patients seen between January 1, 2010 and December 31, 2010 to whom the measures group applies. Unlike the 2009 PQRI, which required that eligible professionals report on consecutive patients (that is, patients seen in order, by date of service), the 30 patients on which an eligible professional would need to report a measures group for 2010 would not need to be consecutive patients. The eligible professional would be able to report on *any* 30 unique patients seen during the reporting period to which the measures group applies. As in previous years, we proposed that for 2010, the patients, for claims-based reporting, would be limited to Medicare Part B FFS patients. For registry-based reporting, however, we proposed that the patients could include some, but not be exclusively, non-Medicare Part B FFS patients.

We solicited comments on our proposal to make the criteria for satisfactory reporting of measures groups more consistent with those proposed for reporting individual measures, including our proposal to revise the minimum sample size requirement related to satisfactory reporting on measures group through the registry-based reporting mechanism so that the criteria for satisfactory reporting of measures groups, regardless of reporting mechanism, would be identical to those proposed for reporting individual measures. We also solicited comments on our proposal to allow eligible professionals to report on measures groups on any 30 patients rather than a consecutive patient sample.

The following is summary of the comments we received regarding the criteria for satisfactory reporting measures groups for individual eligible professionals.

Comment: A few commenters agreed with the proposal to make the criteria for satisfactory reporting of measures groups more consistent with those proposed for reporting individual measures. One commenter cited that doing so makes the program more accessible and improves the commenter's ability to educate their members.

Response: We agree that making the criteria for satisfactory reporting of measures groups more consistent with those proposed for reporting individual measures should facilitate participation and enhance education efforts. For the reasons cited in section II.G.2.e. of this final rule with comment period, we are not finalizing our proposal to add a minimum patient sample requirement to the criteria for satisfactory reporting of individual measures. For the 2010 PQRI criteria for satisfactory reporting of measures groups, however, we will retain the minimum patient sample size requirement for those eligible professionals who choose to report on measures groups based on reporting on 80 percent of applicable patients and will finalize the lower thresholds for the minimum patient sample size requirement proposed for 2010.

Comment: We received numerous comments in support of our proposal to allow eligible professionals to report on measures groups on any 30 patients rather than a consecutive patient sample.

Response: We appreciate the commenters' positive feedback and hope that this change will make measures group reporting a more

attractive option for eligible professionals.

Comment: A few commenters were opposed to removing the requirement that the 30 patients be consecutive. A few commenters expressed that reporting of measures groups on consecutive patients reduces opportunities for selectively reporting patients or cases with more favorable results or would result in reporting on non-representative patient samples. Another commenter suggested the CMS eliminate the option of reporting on 30 patients through claims altogether or allow eligible professionals to report on non-consecutive patients but require a reporting period within which the 30 patients must be selected.

Response: We believe that retaining the option to report on 30 patients provides an incentive to eligible professionals to consider reporting measures groups instead of individual PQRI measures. As we have stated previously, we believe that measures groups enable a more comprehensive assessment of patient care for a given clinical condition or focus by addressing several aspects of care for that particular clinical condition or focus. Because we believe that measures groups may often provide more meaningful information about the care being furnished to Medicare beneficiaries than individual measures reported in isolation, we would like to encourage measures group reporting where possible.

With respect to commenters' concerns that removing the requirement that eligible professionals report on 30 patients, we reiterate that we believe that it would be difficult for eligible professionals to selectively choose which patients to report on since they must report on multiple measures for a given clinical condition or focus. We will, however, continue to monitor the PQRI data to determine whether this needs to be reassessed in future years.

Comment: We received some comments supporting the proposed revisions to the minimum patient sample size requirement for PQRI reporting of measures group (that is, reducing the thresholds from reporting at least 30 patients for at least 1 measures group for the 12-month reporting period and at least 15 patients for at least 1 measures group for the 6-month reporting period to 15 and 8 patients, respectively). Some commenters also remarked that the proposed thresholds were reasonable and appropriate. One commenter, however, remarked that the proposed thresholds were not adequate.

Response: We are finalizing the thresholds as proposed to provide eligible professionals with fewer than 30 patients an opportunity to report on PQRI measures groups for 2010. As identified in Table 8, the new minimum patient sample size thresholds for measures groups reporting for the 2010 PQRI will be 15 patients for at least 1 measures group for the 12-month reporting period and 8 patients for at least 1 measures group for the 6-month reporting period.

As suggested by another commenter, however, we will continue to monitor the PQRI data on an ongoing basis to determine whether the criteria for satisfactory reporting of measures groups, including the minimum patient sample size requirements, need to be re-evaluated for future years.

After considering the comments and for the reasons discussed previously, the final 2010 criteria for satisfactory reporting of data on measures groups are summarized in Table 8 and are arranged by reporting mechanism and reporting period. Accordingly, there are a total of 6 reporting options, or ways in which an eligible professional may meet the criteria for satisfactory reporting of measures groups for the 2010 PQRI. Each reporting option consists of the criteria for satisfactory reporting relevant to a given reporting mechanism and reporting period. As stated previously, while eligible professionals may potentially qualify as satisfactorily reporting on measures groups under more than one of the reporting criteria, reporting mechanisms, and/or for more than one reporting period, only one incentive payment will be made to an eligible professional based on the longest reporting period for which the eligible professional satisfactorily reports. Similarly, an eligible professional could also potentially qualify for the PQRI incentive payment by satisfactorily reporting both individual measures and measures groups. However, only one incentive payment will be made to the eligible professional based on the longest reporting period for which the professional satisfactorily reports.

TABLE 8—2010 CRITERIA FOR SATISFACTORY REPORTING ON MEASURES GROUPS, BY REPORTING MECHANISM AND REPORTING PERIOD

Reporting mechanism	Reporting criteria	Reporting period
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 30 Medicare Part B FFS patients.	January 1, 2010—December 31, 2010.
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1, 2010—December 31, 2010.
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	July 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 30 patients. Patients may include, but may not be exclusively, non-Medicare Part B FFS patients.	January 1, 2010–December 31, 2010.

TABLE 8—2010 CRITERIA FOR SATISFACTORY REPORTING ON MEASURES GROUPS, BY REPORTING MECHANISM AND REPORTING PERIOD—Continued

Reporting mechanism	Reporting criteria	Reporting period
Registry-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	July 1, 2010–December 31, 2010.

g. Reporting Option for Satisfactory Reporting on Quality Measures by Group Practices

As discussed above, for 2010, incentive payments will be available to group practices based on the determination that the group practice, as a whole (that is, for the TIN), satisfactorily reports on PQRI quality measures for 2010. If, however, an individual eligible professional is affiliated with a group practice participating in the group practice reporting option and the group practice satisfactorily reports under the group practice reporting option, the eligible professional will not be eligible to earn a separate PQRI incentive payment for 2010 on the basis of his or her satisfactorily reporting PQRI quality measures data at the individual level under that same TIN (that is, for the same TIN/NPI combination).

(1) Definition of ''Group Practice''

As stated in the proposed rule (74 FR 33570), section 1848(m)(3)(C)(i) of the Act authorizes the Secretary to define ''group practice.'' For purposes of determining whether a group practice satisfactorily submits PQRI quality measures data, we proposed that a ''group practice'' would consist of a physician group practice, as defined by a single TIN, with at least 200 or more individual eligible professionals (as identified by Individual NPIs) who have reassigned their billing rights to the TIN. We solicited comments on the proposed definition of ''group practice'' and our proposal to limit initial implementation of the PQRI group practice reporting option in 2010 to practices with 200 or more individual eligible professionals.

We also proposed to require group practices to complete a self-nomination process and to meet certain technical and other requirements in order to participate in the 2010 PQRI through the group practice reporting option (74 FR 33570). Group practices interested in participating in the 2010 PQRI through the group practice reporting option would be required to submit a self-nomination letter to CMS requesting to participate in the 2010 PQRI group practice reporting option. The following is a summary of the comments received regarding the proposed definition of ''group practice'' and the proposed self-nomination requirements.

Comment: Several commenters requested that we consider allowing smaller group practices to participate in this reporting option. Commenters were concerned that defining a group practice as 200 or more eligible professionals will lead to inaccurate data and further bias. Commenters encouraged us to look for ways to make the option more accessible for most group practices, including those that are not large group practices. Commenters requested that we consider whether in the future smaller group practice sizes should be allowed to participate in this option. Commenters also requested an alternative reporting option that uses statistical sampling for primary care oriented group practices that report measures only applicable to primary care physicians.

Response: We are appreciative of the commenters' thoughtful and constructive feedback and will take these concerns into consideration as we further develop the group practice reporting option. However, the group practice reporting option draws from the experiences of the Physician Group Practice (PGP) demonstration and the Medicare Care Management Performance (MCMP) demonstration. Each of these demonstrations included physician groups, but of different sizes. The PGP demonstration, which the group practice reporting option statistical sampling method is primarily modeled after, has been successful. We recognize that the group practice size of 200 or more individual eligible professionals limits participation. The inclusion of smaller group practices that is those with less than 200 individual eligible professionals, in the group practice reporting option was not proposed at this time because we believe it is unlikely that the smaller groups would be able to achieve 411 assigned Medicare beneficiaries per disease module or preventive care measure that we use under the demonstration. We will use this initial implementation year to further develop and refine aspects of the group practice reporting option and anticipate adapting and expanding this option to group practices less than 200 individual eligible professionals in future program years.

Comment: Several commenters were supportive of the group practice reporting option and thought that the group level data would be more meaningful. Commenters expressed that they are pleased to see the group practice reporting option which has many benefits and that CMS has taken a logical step of initially basing the group reporting process on the PGP and MCMP demonstrations. A commenter stated that group practice reporting option encourages voluntary reporting and promotes better care coordination and a team-based approach to care. One commenter suggested that the group practice reporting option reduces the significant resources which practices currently need to report measures. Another commenter stated the group

practice reporting option allows for increased provider participation and greater transparency in the healthcare provided to Medicare beneficiaries and suggested that the group practice reporting option will bring greater attention to a range of important therapeutic areas.

Response: The group practice reporting option is based on certain aspects of the PGP and the MCMP demonstrations. As defined, the group practice reporting option is intended for large physician groups to report on the high-cost chronic care quality measures for the specific disease modules and preventive care.

Comment: A few commenters supported the proposal for public reporting of group practices' performance results. One commenter, however, did so with the caveat that CMS monitors the results to ensure that there are no unintended consequences.

Response: We appreciate the commenters' positive feedback. As we have stated previously, it is our desire to be able to move towards public reporting of performance results for physicians and other eligible professionals. We believe that public reporting of group practice performance results provides an opportunity to move towards achieving that goal with PQRI data.

Comment: Several commenters were opposed to public reporting of the group practices' PQRI performance results because they believe:

- The reporting process for group practices needs to be further tested to ensure that there are no problems when we implement this process into PQRI, that validity and accuracy of the measures as a reflection of performance, and that there are no unintended consequences;
- CMS does not have specific authority from the Congress to post performance results;
- Doing so would be premature and discourage groups from participating in this option;
- Many issues identified in the CMS Issue Paper: Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physician and Other Professional Services should be addressed prior to public reporting of performance results. Once addressed, public reporting of performance results should be conducted for all PQRI participants, not just group practices;

For similar reasons, other commenters requested that we delay public reporting of the group practices' performance results for at least 1 year or wait until we are fully satisfied with the reliability and validity of the performance data collected from group practices.

Response: Section 1848(m)(3)(C) of the Act requires us to establish a process under which eligible professionals in a group practice shall be treated as satisfactorily submitting data on PQRI quality measures and provides the Secretary with the discretion to determine how to set up this process. For group practices that choose to participate in the PQRI, participation in the group practice reporting option is voluntary. Group practices have a choice as to whether they wish to participate in PQRI with each eligible professional in the group participating individually using one of the reporting options available to individual eligible professionals or to participate as a group through the group practice reporting option.

Furthermore, we believe that public reporting of performance information at the group level does not present some of the same issues that public reporting of performance information at the individual eligible professional would. For example, as we stated in the CY 2010 PFS proposed rule, no performance results would be calculated based on small denominator sizes due to the reporting criteria for the group practice reporting option, which require that group practices report each disease module or preventive care measure under the group practice reporting option for 411 patients. Nevertheless, we take note of the importance of working through the concerns raised by commenters about publicly posting groups' performance results, especially commenters' concerns about doing so in the first year of implementation of the group practice reporting option and the importance of giving participating group practices an opportunity to review their results from the first year of the group practice reporting option before any information is publicly reported. Therefore, we are not finalizing our proposal to require group practices that wish to utilize the group practice reporting option in 2010 to agree to have their PQRI performance results publicly reported. In addition, we will not report any 2010 group practice performance results publicly except as otherwise required by law and will limit public reporting of information on the PQRI group practice reporting for 2010 to the information required by section 1848(m)(5)(G)(i) of the Act (that is, the names of group practices that satisfactorily submitted data on 2010 PQRI quality measures). Instead, we will consider implementing public reporting of group practices' performance results in the 2011 PQRI program year.

For the reasons discussed above and based on these comments, a group practice, for purposes of finalizing the 2010 PQRI group practice reporting option, a group practice will consist of a single TIN with at least 200 or more individual eligible professionals (as identified by Individual NPIs) who have reassigned their billing rights to the TIN. Additionally, the TIN and all Individual NPIs must be established Medicare providers.

To participate in the 2010 PQRI group practice reporting option, a group practice will be required to submit a self-nomination letter indicating the group practice's interest in participating in the 2010 PQRI group practice reporting option. Also, the letter must be accompanied by an electronic file submitted in a format specified by CMS (such as, a Microsoft Excel file) that includes the group practice's TIN and the Individual NPI numbers, name of the group practice, and names of all eligible professionals who will be participating as part of the group practice (that is, all Individual NPI numbers, which are established Medicare providers and associated with the group practice's TIN), a single point of contact for handling administrative issues as well as a single point of contact for technical support purposes. In addition, the self-nomination letter must also indicate the group practice's compliance with the following requirements:

- Have an active IACS user account;
- Agree to attend and participate in all mandatory training sessions; and
- Have billed Medicare Part A and Part B on or after January 1, 2009 and prior to October 29, 2009.

The final participation requirements listed above for group practices, including instructions for submitting the self-nomination letter and other requested information, will be posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* by November 15, 2009. Group practices that wish to self-nominate for 2010 will be required to do so by January 31, 2010. Upon receipt of the self-nomination letters we will assess whether the participation requirements were met by each self-nominated group practice using 2009 Medicare claims data.

As discussed further in section II.G.5. of this final rule, participation in the E-Prescribing Incentive Program is voluntary for group practices selected to participate in the PQRI group practice reporting option. However, we are requiring group practices to participate in the PQRI group practice reporting option in order to be eligible to

participate in the electronic prescribing group practice reporting option. Therefore, a group practice that wishes to participate in both the PQRI group practice reporting option and the electronic prescribing group practice reporting must notify CMS of its desire to do so at the time that it self-nominates to participate in the PQRI group practice reporting option.

(2) Process for Physician Group Practices to Participate as Group Practices and Criteria for Satisfactory Reporting Data on Quality Measures by Group Practices

For physician groups selected to participate in the PQRI group practice reporting option for 2010, we proposed (74 FR 33570) the reporting period would be the 12-month reporting period beginning January 1, 2010. We proposed that group practices would be required to submit information on these measures using a data collection tool based on the data collection tool used in CMS' MCMP demonstration and the quality measurement and reporting methods used in CMS' PGP demonstration. We proposed that physician groups selected to participate in the 2010 PQRI through the group practice reporting option would be required to report on a common set of 26 NQF-endorsed quality measures that are based on measures currently used in the MCMP and/or PGP demonstration and that target high-cost chronic conditions and preventive care.

As part of the data submission process, we proposed that, beginning in 2011, each group practice would be required to report quality measures with respect to services furnished during the 2010 reporting period (that is, January 1, 2010 through December 31, 2010) on an assigned sample of Medicare beneficiaries. We proposed to analyze the January 1, 2010 through October 29, 2010 (that is, the last business day of October 2010) National Claims History (NCH) file to assign Medicare beneficiaries to each physician group practice using the same patient assignment methodology used in the PGP demonstration.

We solicited comments on our proposal to adopt the PGP demonstration's quality measurement and reporting methods for the PQRI group practice reporting option. We specifically requested comments on the proposed patient assignment methodology and our proposal to use a data collection tool based on the one used in the MCMP demonstration as the reporting mechanism for physician groups selected to participate in the PQRI group practice reporting option.

We also proposed 2 criteria for satisfactory reporting of quality measures by a physician group (74 FR 33571). First, the physician group would be required to report completely on all of the proposed modules and measures listed in Table 34 of the proposed rule (74 FR 33588). Second, the physician group would be required to report completely on the first 411 consecutively assigned and ranked Medicare beneficiaries per disease module or preventive care measure.

The following is a summary of the comments we received regarding the proposed reporting option for satisfactory reporting on quality measures by group practices under PQRI.

Comment: One commenter was troubled by our proposal to model the PQRI group practice reporting option on the PGP demonstration since only half of PGP participants earned the incentive payment in the 3rd year of the demonstration. Another commenter noted that transitioning from individual eligible professional reporting to group practice reporting and from pay-for-reporting to pay-for-performance are major and challenging steps.

Response: Although we are planning to model the data collection and sampling process for the PQRI group practice reporting option after the PGP demonstration, we reiterate that the PQRI group practice reporting option is distinct from the PGP demonstration. The requirements to qualify for the incentive for PQRI are different from the requirements to qualify for an incentive payment under the demonstration. Whereas the PGP demonstration is a pay-for-performance demonstration, the PQRI group practice reporting option, like the remainder of the PQRI program, is solely a pay-for-reporting program. Group practices will qualify for a PQRI incentive payment based on meeting the reporting criteria. The PQRI incentive is *not* based on the group practice's performance on the measures nor on cost savings.

Comment: Several Commenters were concerned with the proposed patient assignment methodology. A few commenters asked CMS to reconsider requirements in order to refine the attribution methodology. One commenter opposed the retrospective attribution. One commenter suggested that we limit the E/M visits to primary care physicians selected other specialists, such as endocrinologists and cardiologists, who frequently provide and coordinate care for Medicare beneficiaries. Another commenter recommended the following refinements: (1) Use claims that have the CPT code for ''established'' patients only; (2) use claims that show the place of service code 11 (the code for office visits); and (3) require that the patients have had at least two office visits during the year in order to get into the sample.

Response: For the group practice reporting option, the patient sample will be based on Medicare Part B claims submitted by the group practices' TIN for services provided from January 1, 2010 through October 29, 2010. Only claims appearing in CMS NCH by October 29, 2010, will be considered in the patient sampling and assignment processes. Patients will be assigned to the group practice if they receive the plurality of their Office or Other Outpatient E/M services from the practice. The assigned patients who are selected for quality reporting must have received Office or Other Outpatient E/M services from the practice at least two times in the 10-month period. Furthermore, part-year and managed care patients will not be considered since we have incomplete claims for these individuals and groups may not have had sufficient time to impact the quality of their care. The retrospective attribution will allow CMS to more accurately assign patients using Medicare Part B claims that have been submitted by the group practices' TIN and processed into the NCH.

Comment: One commenter stated that the eligible professionals' affiliation with a group practice will dictate participation. A commenter asked us to allow group practices the flexibility to decide at any stage in the reporting process whether they want to continue with the group reporting process.

Response: The group practice reporting option provides an additional method of participating in PQRI. We do not dictate participation in PQRI, nor do we dictate whether an eligible professional participates in PQRI as an individual or as part of a group. PQRI is a voluntary program. The decision to participate in PQRI is at the discretion of the eligible professional. The eligible professional may participate in PQRI under multiple unique TIN/NPI combinations. An eligible professional may also report via more than one reporting option. The eligible professional cannot, however, receive a duplicate incentive payment for the same TIN/NPI combination.

The eligible professional can receive separate incentive payments by participating and qualifying under one or more unique TIN/NPI combinations. For example, if an eligible professional with TIN/NPI 003/001 participates in the group practice reporting option for one practice and also participates as an

individual using TIN/NPI 005/001 the eligible professional can qualify and earn a separate incentive payment for both TIN/NPI combinations because this is under a different TIN/NPI combination. In the event that a group practice is unsuccessful with the group practice reporting option, we will not conduct analysis to determine if the TIN/NPI qualified and is incentive eligible for other methods of PQRI participation. There is no appeals process for PQRI.

Comment: One commenter asked that we provide a mechanism for allowing group practices to deselect patients who have been assigned to the group practice.

Response: We understand that due to circumstances out of the groups' control (that is, death, unable to locate a medical record, etc.) that the group practice may not be able to report completely on 100 percent of the first 411 consecutively ranked assigned patient sample. The reporting tool allows for exclusions in certain instances and the group will not be required to populate the tool when these circumstances arise. In order to accommodate for such issues, each group practice will be assigned an over sample of patients, which will assure that the group practice reports completely on 411 consecutively assigned patients per disease module and preventive care measure to report on. The experience from the PGP demonstration has shown that this sampling method provides a sufficient number of assigned patients in the event that the deselection of assigned patients is warranted.

Comment: One commenter specifically supported using the Performance Assessment Tool (PAT), which is the data collection tool used in the PGP and MCMP demonstrations and proposed for use in PQRI group practice reporting option. Another commenter supports using the PAT and applauds quick turnaround time we anticipate for providing pre-populated results to practices.

Response: We appreciate the commenters' support for the data collection tool. We anticipate providing the selected group practices with a pre-populated data collection tool. Data fields will be pre-populated based on Medicare claims and demographic information for dates of service between January 1, 2010 and October 29, 2010. This tool will be modeled after the PAT currently in use for the MCMP program, with some modifications. The tool will require, at a minimum, standard PC image with Microsoft Office and Microsoft Access software installed and minimum software configurations for the group practices to successfully complete the data collection tool. The data collection tool may potentially provide a high level feedback (submission) report to the group practice, including such information as percentage of patients that have been completed in the sample and percentage of positive measure results. These features will allow the group practices to verify data prior to submitting it to us. We reserve the right to audit the data submitted by the group practices.

Comment: One commenter stated that only those group practices that have participated in the PGP demonstration will be successful in completing the tool and participating in the group practice reporting option.

Response: Group practices participating in the PGP demonstration will not be allowed to participate in the PQRI group practice reporting option in 2010. We acknowledge that there will be a learning period needed to become familiar with and to complete the tool. Group practices that are selected to participate in the PQRI group practice reporting option will be required to attend mandatory training sessions. Prior to these mandatory training sessions, we anticipate providing the group practices with a sample tool to become familiar with its functionality and reporting process. Additionally, we may establish periodic conference calls with the group practices, with most calls being held during the tool data entry period, to provide technical support to practices. The group practices will be required to designate administrative and technical points of contact to streamline and assist with communication.

Comment: One commenter stated that it would be challenging for group practices to report on 26 measures.

Response: We disagree that it would be challenging for group practices to report on 26 measures. We will be prepopulating the data collection tool that will be used for the PQRI group practice reporting option with claims and other demographic information on the group practices' assigned Medicare beneficiaries prior to sending the data collection tool to the groups to complete. Furthermore, we believe the burden of reporting the 26 measures is outweighed by the potential incentive payment. Completion of this data collection tool on all 26 measures for the required number of patients essentially qualifies the group practice for an incentive payment equal to 2.0 percent of the group practice's estimated total Medicare Part B PFS allowed charges for services furnished during the reporting period.

For the reasons discussed above and after taking into consideration the comments, we are finalizing the process group practices will be required to use to report data on quality measures for the 2010 PQRI as a group practice and the associated criteria for satisfactory reporting of data on quality measures by group practices, which are summarized in Table 9. Group practices participating in PQRI as a group practice will be required to report on all of the measures listed in Table 28 of this final rule with comment period. These quality measures are grouped into preventive care measures and four disease modules: diabetes; heart failure; coronary artery disease; and hypertension.

Although the process for physician groups to participate in PQRI as a group practice incorporates some characteristics and methods from the PGP demonstration and the MCMP demonstration, the PQRI group practice reporting option is a separate program with its own specifications and methodology from the PGP and MCMP demonstration programs. The reporting process for the group practice reporting option, including the use of a data collection tool as the reporting mechanism, will not be available to individual eligible professionals participating in the 2010 PQRI.

As stated in the proposed rule (74 FR 33570 through 33571), we will analyze the January 1, 2010 through October 29, 2010, NCH file to assign Medicare beneficiaries to each physician group practice using the same patient assignment methodology used in the PGP demonstration. Assigned beneficiaries will be limited to those Medicare FFS beneficiaries with Medicare Parts A and B for whom Medicare is the primary payer. Assigned beneficiaries will not include Medicare Advantage enrollees. A beneficiary will be assigned to the physician group that provides the plurality of a beneficiary's office or other outpatient E/M allowed charges (based on Medicare Part B claims submitted for the beneficiary for dates of services between January 1, 2010 and October 29, 2010). Beneficiaries with only 1 visit to the group practice between January 1, 2010 and October 29, 2010, will be eliminated from the group practice's assigned patient sample. For inclusion in the sample, beneficiaries will be required to have at least 2 visits to the group practice between January 1, 2010 and October 29, 2010.

Once the beneficiary assignment has been made for each physician group

during the fourth quarter of 2010, we will provide each physician group selected to participate in the group practice reporting option with access to a database (that is, a data collection tool) that will include the group's assigned beneficiary samples and the quality measures listed in Table 28. We will prepopulate the data collection tool with the assigned beneficiaries' demographic and utilization information based on all of their Medicare claims data. We intend to provide the selected physician groups with access to this prepopulated database by no later than the first quarter of 2011. The physician group will be required to populate the remaining data fields necessary for capturing quality measure information on each of the assigned beneficiaries. Numerators for each of the quality measures will include all beneficiaries in the denominator population who also satisfy the quality performance criteria for that measure. Denominators for each quality measure will include a sample of the assigned beneficiaries who meet the eligibility criteria for that disease module or each preventive care quality measure. All of the assigned patients' inpatient, outpatient, and physician claims will be used in determining clinical eligibility for each module. Identical to the sampling method used in the PGP demonstration, the random sample must consist of at least 411 assigned beneficiaries. If the pool of eligible assigned beneficiaries is less than 411, then the group practice must report on 100 percent, or all, of the assigned beneficiaries to satisfactorily participate in the group practice reporting option. For each disease module or preventive care measure, the physician group will be required to report information on the assigned patients in the order in which they appear in the group's sample (that is, consecutively).

TABLE 9—2010 PROCESS FOR PHYSICIAN GROUP PRACTICES TO PARTICIPATE AS GROUP PRACTICES AND CRITERIA FOR SATISFACTORY REPORTING OF DATA ON QUALITY MEASURES BY GROUP PRACTICES

Reporting mechanism	Reporting criteria	Reporting period
• A pre-populated data collection tool provided by CMS.	• Report on all measures included in the data collection tool (26 measures); and • Complete the tool for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries.	January 1, 2010–December 31, 2010.

h. Statutory Requirements and Other Considerations for 2010 PQRI Measures

(1) Statutory Requirements for 2010 PQRI Measures

As discussed in the proposed rule (74 FR 33571 through 33572), the statutory requirements with respect to the use of quality measures for the 2010 PQRI are different from the statutory requirements for previous program years. For purposes of reporting data on quality measures for covered professional services furnished during 2010 and subsequent years for the PQRI, subject to the exception noted below, section 1848(k)(2)(C)(i) of the Act, as added by MIPPA, requires that the quality measures shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under subsection 1890(a) of the Act (that is, the National Quality Forum, or NQF). In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the NQF, however, section 1848(k)(2)(C)(ii) of the Act authorizes the Secretary to specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance.

Finally, section 1848(k)(2)(D) of the Act requires that for each 2010 PQRI quality measure, ''the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish.''

(2) Other Considerations for Measures Selected for Inclusion in the 2010 PQRI

Based on the statutory requirements described above, we stated in the CY 2010 PFS proposed rule (74 FR 33572 through 33573) that we proposed to apply the following considerations with respect to the selection of 2009 PQRI quality measures for inclusion in the 2010 PQRI quality measure set:

• Where some 2009 PQRI quality measures have been endorsed by the NQF and others have not, those 2009 PQRI quality measures that have been specifically considered by NQF for possible endorsement, but NQF has declined to endorse it, will not be included in the 2010 PQRI quality measure set (that is, we will retire the measure for 2010).

• In circumstances where no NQF-endorsed measure is available, we will exercise the exception under section 1848 (k)(2)(C)(ii) of the Act. Under these circumstances, a 2009 PQRI quality measure that previously (that is, prior to January 31, 2009) has been adopted by the AQA will meet the requirements under the Act and it would be appropriate for eligible professionals to use the measure to submit quality measures data and/or quality measures results and numerator and denominator data on quality measures, as appropriate.

• Although we are not including any 2009 PQRI measures that have not been endorsed by the NQF or adopted by the AQA in the final 2010 PQRI quality measure set, we acknowledge that section 1848(k)(C)(ii) of the Act provides an exception to the requirement that the Secretary select measures that have been endorsed by the entity with a contract under section 1890(a) of the Act (that is, the NQF) as long as an area or medical topic for which a feasible and practical NQF-endorsed measure is not available has been identified and due consideration has been given to measures that have been endorsed by the NQF and/or, prior to January 31, 2009, adopted by the AQA.

• The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted above, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) (that is, the NQF) and are silent with respect to how the measures that are submitted to the NQF for endorsement were developed. The basic steps for

developing measures applicable to physicians and other eligible professionals prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards.

• 2009 PQRI measures that were part of the 2007 and/or 2008 PQRI in which the 2007 and 2008 PQRI analytics indicate a lack of significant reporting and usage were not considered for inclusion in the 2010 PQRI.

In addition to reviewing the 2009 PQRI measures and previously retired measures, for purposes of developing the proposed 2010 PQRI measures, we reviewed and considered measure suggestions including comments received in response to the CY 2009 PFS proposed rule and final rule with comment period. Additionally, suggestions and input received through other venues, such as an invitation for measures suggestions posted on the PQRI section of the CMS Web site in February 2009 were also reviewed and considered for purposes of our development of the list of proposed 2010 PQRI quality measures. All measures and measures groups reviewed for potential inclusion in the 2010 PQRI measure set are listed in the ''Table of 2010 Measure Suggestions'' posted on the Statute/Regulations/Program Instructions page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/05_StatuteRegulationsProgramInstructions.asp#TopOfPage.*

With respect to the selection of new measures (that is, measures that have never been selected as part of a PQRI quality measure set for 2009 or any prior year), we stated in the CY 2010 PFS proposed rule (74 FR 33572 through 33573) that we would apply the following considerations, which include many of the same considerations applied to the selection of 2009 PQRI quality measures for inclusion in the 2010 PQRI quality measure set described above:

• High Impact on Healthcare.

+ Measures that are high impact and support CMS and HHS priorities for improved quality and efficiency of care for Medicare beneficiaries. These current and long term priority topics include: prevention; chronic conditions; high cost and high volume conditions; elimination of health disparities; healthcare-associated infections and other conditions; improved care coordination; improved efficiency; improved patient and family experience of care; improved end-of-life/palliative care; effective management of acute and chronic episodes of care; reduced unwarranted geographic variation in quality and efficiency; and adoption and use of interoperable HIT.

+ Measures that are included in, or facilitate alignment with, other Medicare, Medicaid, and CHIP programs in furtherance of overarching healthcare goals.

• NQF Endorsement.

+ Measures must be NQF-endorsed by July 1, 2009, in order to be considered for inclusion in the 2010 PQRI quality measure set.

+ Although we did not propose to include any new measures that were not endorsed by the NQF by July 1, 2009 in the final 2010 PQRI quality measure set, we acknowledge that section(k)(2)(C)(ii) of the Act provides an exception to the requirement that the Secretary select measures that have been endorsed by the entity with a contract under section 1890(a) of the Act (that is, the NQF). As long as an area or medical topic for which a feasible and practical NQF-endorsed measure is not available has been identified and due consideration has been given to measures that have been adopted by the AQA or other consensus organization identified by the Secretary.

+ The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted above, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) (that is, the NQF) and are silent with respect to how the measures that are submitted to the NQF for endorsement were developed. The basic steps for developing measures applicable to physicians and other eligible professionals prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards. The requirements under section 1848(k)(2)(C) of the Act pertain only to the selection of measures and not to the development of measures.

• Address Gaps in PQRI Measure Set.

+ Measures that increase the scope of applicability of the PQRI measures to services furnished to Medicare beneficiaries and expand opportunities for eligible professionals to participate in PQRI. We seek to achieve broad ability to assess the quality of care furnished to Medicare beneficiaries, and ultimately to compare performance among professionals. We seek to increase the circumstances where eligible professionals have at least three measures applicable to their practice and measures that help expand the number of measures groups with at least four measures in a group.

+ Measures of various aspects of clinical quality including outcome measures, where appropriate and feasible, process measures, structural measures, efficiency measures, and measures of patient experience of care.

Other considerations that we proposed to apply to the selection of measures for 2010, regardless of whether the measure is a 2009 PQRI measure or not, were:

• Measures that are functional, which is to say measures that can be technically implemented within the capacity of the CMS infrastructure for data collection, analysis, and calculation of reporting and performance rates. This leads to preference for measures that reflect readiness for implementation, such as those that are currently in the 2009 PQRI program or have been through testing. The purpose of measure testing is to reveal the measure's strengths and weaknesses so that the limitations can be addressed and the measure refined and strengthened prior to implementation. For new measures, preference is given to those that can be most efficiently implemented for data collection and submission. Therefore, any measures that have been found to be technically impractical to report because they are analytically challenging due to any number of factors, including those that are claims-based, have not been included in the 2010 PQRI. For example, in some cases, we are replacing existing 2009 PQRI measures with updated and improved measures that are less technically challenging to report.

• For some measures that are useful, but where data submission is not feasible through all otherwise available PQRI reporting mechanisms, a measure may be included for reporting solely through specific reporting mechanism(s)

in which its submission is feasible. For example, we proposed to limit reporting of some measures that previously were available for claims-based reporting and registry-based reporting to registry-based reporting only because they were technically challenging to report and/or analyze through the claims-based reporting mechanism (74 FR 33579 through 33580).

We also reviewed 33 measures that have been retired from the PQRI in previous years using the considerations for selecting measures for the 2010 PQRI discussed above (74 FR 33573). None were found to be eligible for inclusion in the 2010 PQRI quality measure set because they did not meet the criteria described above.

We solicited comments on the implication of including or excluding any given measure or measures in the final 2010 PQRI quality measure set and to our approach in selecting measures. As we stated in the proposed rule, we recognize that some commenters may also wish to recommend additional measures for inclusion in the 2010 PQRI measures that we did not propose (74 FR 33573). While we may consider such recommended measures for inclusion in future measure sets for PQRI and/or other programs to which such measures may be relevant, we will not be able to consider such additional measures for inclusion in the 2010 measure set.

(3) Summary of Comments and Responses

The following is a summary of the comments we received regarding the statutory requirements and other considerations for the selection of 2010 PQRI measures.

Comment: Some commenters appreciated our continued efforts to expand the PQRI quality measure set with measures that are scientifically valid and minimize eligible professional burden. In order to promote the provisions that reflect up-to-date care for beneficiaries as the program matures, these commenters urged us to revise its quality measures regularly to reflect current guidelines.

Response: We appreciate these supportive comments regarding our continued efforts to expand the PQRI quality measure set. As the program evolves, we will continue to consider more effective processes to update and/or revise the PQRI quality measure set to reflect the most current guidelines of care.

Comment: Several commenters supported our proposal to only use quality measures that have been endorsed by the NQF, thereby ensuring a rigorous evaluation of the measures by multiple stakeholders and providing an opportunity for public comment from those various stakeholders. These commenters suggested the utilization of NQF endorsed measures reflect areas that are common to providers, allow for appropriate measurement of services provided in Medicare, and provide a thorough standardized review framework. One commenter, however, was unclear whether NQF or consensus organization endorsement or adoption is required for all suggested measures for 2010 or 2011 or whether the Secretary can suggest measures of her own accord when measures do not already exist with this endorsement.

Response: We appreciate the commenters' supportive feedback and agree with the points raised by the commenters with respect to the benefits of NQF endorsement. As we stated above, subject to the exception under section 1848(k)(2)(C)(ii) of the Act, measures selected for the 2010 PQRI are required by section 1848(k)(2)(C)(i) of the Act to be endorsed by Secretary. Section 1848(k)(2)(C)(ii) of the Act authorizes us to select measures for the 2010 PQRI and subsequent years that have not been endorsed by the NQF in a specified area or medical topic for which a feasible and practical measure has not been so endorsed as long as we give due to consideration to measures that have been endorsed or adopted by other consensus organizations identified by the Secretary.

Comment: One commenter notes that the proposed rule makes allowance for measures used in the 2009 PQRI that have not been endorsed by the NQF but were previously approved by the AQA. The commenter believes that for new measures, NQF endorsement should be a requirement not only for the PQRI measures but also for measures for the hospital outpatient quality data reporting program, or HOP QDRP. While the underlying statutes for both reporting programs differ, the commenter believes CMS has the discretion to adopt a consistent policy with respect to NQF endorsement.

Response: As discussed previously, the requirements for measures selected for the PQRI are defined in statute. The requirements for other quality data reporting programs are beyond the scope of this rule.

Comment: Some commenters recommended that we require NQF endorsement not only of individual measures, but also NQF endorsement of measures groups.

Response: When we create measures groups, we only utilize individual measures that meet statutory requirements. All measures in current measures groups meet the statutory requirements. We are unaware of any efforts by NQF to review groups of measures for separate endorsement. Section 1848(m)(5)(F) of the Act required us to establish alternative criteria for satisfactorily reporting and alternative reporting periods for reporting groups of measures for 2008 and subsequent years but did not establish any additional limitations on the discretion of the Secretary.

Comment: Some commenters urged us to recognize additional consensus organizations to endorse quality measures for the PQRI. The commenters suggested we recognize measure development organizations such as the American Medical Association's Physician Consortium for Performance Improvement (AMA–PCPI) or the National Committee for Quality Assurance (NCQA) as consensus endorsement organizations.

Response: MIPPA modified the requirements for measure selection by the Secretary for PQRI as previously described. Further, as we stated in response to similar comments in previous years, we are unaware of other consensus organizations that are comparable to the NQF in terms of meeting the formal requirements of the NTTAA or of organizations other than AQA that do not strictly meet the requirements of the National Institute of Standards and Technology Act (NISTA), as amended by the NTTAA but that feature the breadth of stakeholder involvement in the consensus process necessary to meet the intent of the Act.

Comment: One commenter suggested that the measure development process should not be restricted to physician-controlled organizations but that the measure development process must include relevant physician input due to their expertise in the subject areas.

Response: We are in agreement that while physician expertise is an important ingredient in measure development and in the consensus process, physicians should not be in complete control of the process of measure development. Any such restriction would unduly limit the basic development of physician quality measures.

Comment: A few commenters did not believe that endorsement or adoption by the NQF or the AQA, respectively, was a necessary condition for inclusion of a measure in the PQRI for 2010 or subsequent years. One commenter urged us to use measures from other nationally recognized sources in areas for which NQF-endorsed measures are not available on the condition that the

measures are expedited through the NQF endorsement process.

Response: We agree that NQF endorsement or AQA adoption is not a necessary condition for all measures included in the PQRI quality measure set. As stated previously, section 1848(k)(2)(C)(ii) of the Act does permit us to select measures for the 2010 PQRI and subsequent years that have not been endorsed by the NQF in a specified area or medical topic for which a feasible and practical measure has not been so endorsed as long as we give due consideration to measures that have been endorsed or adopted by other consensus organizations identified by the Secretary.

We proposed to exercise this authority for 2010 in the CY 2010 PFS proposed rule (74 FR 33576 through 33579) by proposing to include in the 2010 PQRI several 2009 PQRI measures that had not yet achieved NQF endorsement but that were AQA adopted. As we stated in the proposed rule, we would include such measures in the 2010 PQRI as long as a measure had not been reviewed by the NQF prior to July 1, 2009 and specifically declined for endorsement.

We are also exercising this authority with respect to our decision to finalize 3 proposed new measures (that is, Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear; Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear within the Previous 90 days; and Referral for Otologic Evaluation for Patients with History of Sudden or Rapidly Progressive Hearing Loss) that were neither NQF endorsed prior to July 1, 2009 nor AQA adopted prior to January 31, 2009. We decided to finalize these 3 measures despite the lack of consensus endorsement or adoption due to the lack of measures available for audiologists to report on. Audiologists are a new a category of eligible professionals that were added to the list of professionals eligible to participate in the PQRI beginning with the 2009 PQRI.

We stress, however, that inclusion of measures that are not NQF endorsed or AQA adopted is an exception to the requirement under section 1848(k)(2)(C)(i) of the Act that measures be endorsed by the NQF. Therefore, we do believe that this exception authority should be exercised in very limited circumstances, such as when few or no measures are available for a particular specialty or category of eligible professionals to report.

Comment: Several commenters suggested what the PQRI quality measure set should focus on and how the PQRI quality measure set should evolve. One commenter believes the PQRI quality measure set should evolve with the development of better clinical evidence and a greater understanding of the benefit-cost tradeoffs of particular services and treatments. Another commenter urged us to adopt quality measures that would address the existing gaps in quality and that focus on services with the potential to deliver high value to Medicare beneficiaries and to avoid services that may have little or no value to beneficiaries, such as high-cost or high-volume services. One commenter suggested additional criteria that should be utilized in the selection of measures, which include selecting: (1) More outcome and resource use measures; (2) care coordination measures; (3) measures addressing appropriateness of care which deliver high value to Medicare patients; (4) measures that allow for assessing and reporting on disparities of care. Some commenters also believe the measures selected for PQRI should not reward eligible professionals for providing marginally effective care or care that is already routinely furnished.

Response: In the 2010 PFS proposed rule, we listed the considerations that we applied for the selection of proposed 2010 PQRI quality measures. As described above, many of these considerations reflect the commenters' suggestions, particularly our focus on:

- Measures with high impact on healthcare.
- Measures that support CMS and HHS priorities for improved quality and efficiency of care for Medicare beneficiaries (such as, prevention; chronic conditions; high cost and high volume conditions; elimination of health disparities; healthcare-associated infections and other conditions; improved care coordination; improved efficiency; improved patient and family experience of care; improved end-of-life/palliative care; effective management of acute and chronic episodes of care; reduced unwarranted geographic variation in quality and efficiency; and adoption and use of interoperable HIT).
- Measures that are included in, or facilitate alignment with, other Medicare, Medicaid, and CHIP programs in furtherance of overarching healthcare goals.
- Measures that address gaps in the PQRI measure set in order to increase the scope of applicability of the PQRI measures to services furnished to Medicare beneficiaries and expand opportunities for eligible professionals to participate in PQRI.

Comment: Some commenters encouraged us to identify and add more quality measures and to develop interim opportunities for eligible professionals that have a dearth of available measures to participate in PQRI. One commenter specifically recommended that we expand the number of measures to reflect all types of services provided to all beneficiaries.

Response: Despite our efforts to expand the PQRI quality measure set to increase the scope of applicability of the PQRI measures to services furnished to Medicare beneficiaries and expand opportunities for eligible professionals to participate in PQRI, we are aware that there remains some gaps in the PQRI quality measure set. However, we largely depend on the development of measures by professional organizations and other measure developers. Although we had significant involvement in the development of measures applicable to eligible professionals at the start of the PQRI, ideally we would not need to be closely involved in the development of clinician-level quality measures but would select from measures that meet the statutory requirements. Thus, we encourage professional organizations and other measure developers to fund and develop measures that address some of the gaps identified by the commenters.

Comment: Some commenters recommended we utilize data from previous reporting periods to determine the appropriateness and effectiveness of the measures. The commenters recommended that we continually evaluate and revise the criteria for measure selection to ensure measures align with clinical practice and can be reported with minimal administrative burden.

Response: We will continue to evaluate data from previous reporting periods to assess the appropriateness and effectiveness of the PQRI measures. We will also continue to work with measure developers to urge alignment of the PQRI measures with clinical practice as the program evolves and matures.

i. The Final 2010 PQRI Quality Measures for Individual Eligible Professionals

For 2010, we proposed that final PQRI quality measures would be selected from 153 of the 2009 PQRI measures and the measures listed in the ''Table of 2010 Measure Suggestions'' posted on the Statute/Regulations/Program Instructions page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/05_StatuteRegulationsProgramInstructions.asp#*

TopOfPage. We proposed to include a total of 176 measures (this includes both individual measures and measures that are part of a proposed 2010 measures group) on which individual eligible professionals can report for the 2010 PQRI (74 FR 33574 through 33587, and 39032). In addition, we proposed to retire 7 measures because they did not meet one or more of the considerations for selection of proposed 2010 measures (74 FR 33574). In addition we proposed 13 measures groups for the 2010 PQRI (74 FR 33582 through 33587).

The following is a summary of the comments received on the 2010 PQRI measures in general and comments on the measures from the 2009 PQRI not proposed for inclusion in the 2010 PQRI, which are addressed below. Comments specific to measures proposed for inclusion in the 2010 PQRI are addressed in sections II.G.2.i.1. through II.G.2.i.5. below.

Comment: Several commenters requested or recommended that we make readily available on an ongoing basis more detailed information on the measure development process and on measures in development.

Response: We agree that it is desirable for the public to have information on the measures development process and measures in development. To this end, we have developed a standardized process to be used for CMS contracted measures development. This standardized process is detailed in the ''Measures Management System Blueprint'' found on the CMS Web site at *http://www.cms.hhs.gov/apps/QMIS/mmsBlueprint.asp*.

As stated previously, however, we largely depend on the development of measures by professional organizations and other measure developers for the PQRI. Many major measures developers follow a similar process for the measures that they develop, in that they publish measures and specifications during development and seek public comment. Both the NQF and AQA also publish measures and specifications during their consensus processes and seek public comment.

Comment: Numerous commenters requested final measure specifications for the 2010 PQRI be published as far in advance of the beginning of the reporting period as possible, and that more detailed information about measures proposed or finalized for use in PQRI be published at the same time as or in advance of future rulemaking.

Response: We agree with the commenters that it is desirable to provide final measure specifications sufficiently in advance of the reporting period to allow reasonable time for professionals to analyze new or revised measures and implement any needed changes in their office workflows to accurately capture and successfully submit data on a selection of measures applicable to their practice on which they can act to improve the quality of the services they furnish.

Having detailed information on measures available in advance of the reporting period also enhances the ability of vendors (such as practice management software, billing services, and electronic health records vendors) to support professionals' successful implementation of revised data-capture processes for the measures. Our intent is to provide the final list of 2010 PQRI measures and the detailed measures specifications on the PQRI section of the CMS Web site by November 15, 2009, but no later than December 31, 2009. These detailed specifications will include instructions for reporting and identifying the circumstances in which each measure is applicable. The detailed technical specifications for measures in the final listing for the 2010 PQRI remain potentially subject to corrections until the start of the 2010 reporting period, as we stated in the proposed rule.

Comment: One commenter supported removal from the PQRI quality measure set for 2010 and 2009 PQRI measure that was part of the 2007 and/or 2008 PQRI for which the 2007 and 2008 PQRI analytics indicate a lack of significant reporting and usage. The commenter remarked that continued review and revision of the measures list will help to refine the process and validity of the program and reduce undue burden on participants, increasing meaningful participation.

Response: We appreciate the commenter's constructive feedback and agree that it is necessary to review and revise the PQRI quality measure set on an ongoing basis as we gain more experience with particular measures and/or new measures become available to replace existing measures.

We are unclear, however, with respect to the commenter's remark that continued revision of the PQRI quality measure set will reduce undue burden on participants. Although there are several measures available in the PQRI quality measure set, participants are not required, nor are they expected to, report on all measures included in the PQRI quality measure set. As discussed further in sections II.G.2.e. and II.G.2.f. above, an individual eligible professional generally needs to report on only 3 individual 2010 PQRI quality measures or 1 2010 PQRI measures group in order to meet the criteria for satisfactory reporting for 2010.

Comment: Some commenters specifically suggested that Measure #143 Oncology: Medical and Radiation—Pain Intensity Quantified and Measure #144 Oncology: Medical and Radiation Plan of Care for Pain be retained for the 2010 PQRI because they believe the measures address quality of life issue for patients with cancer. One commenter requested that if the measures are analytically challenging as claims-based measures, we retain the measures as registry-only measures instead.

Response: We only proposed to retire these measures because they were too complex to calculate via claims. Based on the commenter's suggestion to retain these measures as registry-only measures for the 2010 PQRI, we are finalizing and including them in the measures listed in ''Table 11: 2010 Measures Selected From the 2009 PQRI Quality Measure Set Available for Registry-based Reporting Only.''

Comment: One commenter requested that Measure #94 Otitis Media with Effusion (OME): Diagnostic Evaluation—Assessment of Tympanic Membrane Mobility and Measure #95 Otitis Media with Effusion (OME) Hearing Testing not be retired since audiologists were just added to the list of eligible professionals with the 2009 PQRI and there are few measures on which they can report. The commenter requested that we retain both measures for at least an additional year to reassess the level of use since PQRI reporting, for audiologists, is a new process that requires extensive training.

Response: We agree that in order to provide audiologists with opportunities to participate in the PQRI, it is necessary to retain at least one of these measures for at least another year. Thus, we have decided to retain Measure #94 Otitits Media with Effusion (OME): Diagnostic Evaluation—Assessment of Tympanic Membrane Mobility and retire only Measure #95 Otitis Media with Effusion (OME) Hearing Testing for 2010. Measure #94, in conjunction with the 3 new measures developed by the Audiology Quality Consortium (AQC) listed in Table 13, will provide audiologists with at least 4 measures on which they can report for the 2010 PQRI.

Comment: One commenter was not clear on which measure was being proposed to replace Measure #34 Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (tPA) Considered and requested that CMS not retire Measure #34 until clarification is provided. Another commenter,

however, supported the retirement of Measure #34 and CMS' decision to replace this measure with the proposed new Stroke and Stroke Rehabilitation: Thrombolytic Therapy measure (see Table 19 of the CY 2010 PFS proposed rule).

Response: As indicated by the commenter, we are replacing Measure #34 with the Stroke and Stroke Rehabilitation: Thrombolytic Therapy measure listed in Table 13 of this final rule with comment period.

Comment: One commenter expressed support for a proposed revision of Measure #11 for 2010 PQRI that expands the eligible denominator patient population.

Response: We wish to clarify that at the request of the measure developer, we are retiring Measure #11 and replacing it with the proposed new NQF-endorsed measure: Stenosis Management in Cardiac Imaging Studies (see Table 13 of this final rule with comment period).

Based on the criteria discussed above and our review of these comments, we are retiring the 4 measures listed in Table 10 and are including the 175 individual measures listed in Tables 11 through 13 in the final 2010 PQRI individual quality measure set. We are also including 13 measures groups in the final 2010 PQRI quality measure set, which are listed in Tables 15 through 27. The individual measures selected for the 2010 PQRI can be categorized as follows:

(1) 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Claims-based Reporting and Registry-Based Reporting;

(2) 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Registry-based Reporting Only;

(3) New Individual Quality Measures Selected for 2010; and

(4) 2010 Measures Available for EHR-based Reporting.

TABLE 10—2009 PQRI QUALITY MEASURES NOT INCLUDED IN THE 2010 PQRI

Measure No.	Measure title
11	Stroke and Stroke Rehabilitation: Carotid Imaging Reporting.
34	Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (tPA) Considered.
95	Otitis Media with Effusion (OME): Hearing Testing.
152	Coronary Artery Disease (CAD): Lipid Profile in Patients with CAD.

(1) 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Claims-based Reporting and Registry-based Reporting

We proposed to include in the 2010 PQRI quality measure set 116 of the 2009 PQRI measures, which would be available for either claims-based reporting or registry-based reporting as individual quality measures (74 FR 33574 through 33579). We also noted that one of the proposed measures, Measure #46 Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility, is reportable through the registry-based reporting mechanism only in the 2009 PQRI. However, for the 2010 PQRI, we proposed to make this measure available for either claims-based reporting or registry-based reporting.

These 116 proposed measures did not include any measures that were proposed to be included as part of the 2010 Back Pain measures group. Similar to the 2009 PQRI, we proposed that any 2010 PQRI measure that is included in the Back Pain measures group would not be reportable as individual measures through claims-based reporting or registry-based reporting.

The following is a summary of the comments received on the 116 proposed measures selected from the 2009 PQRI quality measure set.

Comment: We received numerous comments in support of the 2009 PQRI quality measures proposed for inclusion in the 2010 PQRI. Several commenters supported the retention of all the 2009 PQRI measures proposed for 2010. Other commenters supported inclusion of specific 2009 PQRI measures in the 2010 PQRI. Measures on which we received specific support include:

- Measure #1 Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus;
- Measure #2 Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus;
- Measure #3 Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus;
- Measure #9 Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD;
- Measure #18 Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy;
- Measure #19 Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care;
- Measure #67 Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow;
- Measure #68 Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythopoietin Therapy;
- Measure #102 Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients;
- Measure #104 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients;
- Measure #105 Prostate Cancer: Three-Dimensional (3D) Radiotherapy;
- Measure #106 Major Depressive Disorder (MDD): Diagnostic Evaluation;
- Measure #107 Major Depressive Disorder (MDD): Suicide Risk Assessment;
- Measure #110 Preventive Care and Screening: Influenza Immunization for Patients ≥50 Years Old;
- Measure #111 Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older;
- Measure #112 Preventive Care and Screening: Screening Mammography;
- Measure #113 Preventive Care and Screening: Colorectal Cancer Screening;
- Measure #114 Preventive Care and Screening: Inquiry Regarding Tobacco Use;
- Measure #115 Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit;
- Measure #117 Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient;
- Measure #119 Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients;
- Measure #124 Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR);
- Measure #126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy-Neurological Evaluation;
- Measure #127 Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention—Evaluation of Footwear;
- Measure #134 Screening for Clinical Depression and Follow-Up Plan;
- Measure #136 Melanoma: Follow-Up Aspects of Care;
- Measure #137 Melanoma: Continuity of Care—Recall System;
- Measure #138 Melanoma: Coordination of Care;
- Measure #156 Oncology: Radiation Dose Limits to Normal Tissues; and
- Measure #163 Diabetes Mellitus: Foot exam.

Response: All 116 of the proposed measures listed in Table 17 of the proposed rule (74 FR 33575 through 33579), including all of the measures specifically supported by commenters, have been finalized for the 2010 PQRI, and are included in Table 11.

Comment: One commenter commended CMS on the format of Table 17 of the proposed rule (74 FR 33575 through 33579) which clearly stated the status of NQF endorsement, AQA adoption, and the measure developer for each proposed measure. The commenter encouraged us to use this format in future rules.

Response: We appreciate the positive feedback on the newly formatted tables in the proposed rule.

Comment: One commenter urged us to finalize the proposed new measures related to age-related macular degeneration, osteoporosis, and cancer care and to work with the community to ensure these measures are appropriately reported.

Response: We note that the measures referenced by the commenter are existing 2009 PQRI measures that will be included for 2010 PQRI. As noted previously, we have developed an education and outreach plan that is continuously expanding in scope in our efforts to educate eligible professionals on the nuances of the PQRI, including educating eligible professionals and office staff on appropriate reporting of the PQRI measures.

Comment: Several commenters recommended changes to specific quality measures' titles, definitions, and detailed specifications or coding. Many of these recommendations were based on alternative interpretations of clinical evidence or concerns about the utility of the measures. Some requests were specifically concerned that measures be expanded to include specific professionals to whom the measure may be applicable such as physical therapists, audiologists, and hospitalists.

Specifically, one commenter suggested that in order to maximize the impact of Measure #1 Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus, the PQRI specification should continue to require a performance period of 12 months and reporting that identifies whether A1c control is good (that is, A1c ≤ 7.0 percent), moderate (that is, A1c ≤ 9.0 percent, but > 7.0 percent), or poor (that is, A1c > 9.0 percent).

Another commenter suggested that audiologists should be included in Measure #154 Falls: Risk Assessment. The commenter noted that audiologists are consulted to provide vestibular rehabilitation that results in improved quality of care for these patients and reduces unnecessary and excessive cost.

Another commenter requested that Measure #52 Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation needs to be re-evaluated and CMS should consider modifying this measure or creating a new one that addresses the appropriate use of LABA.

We received one comment regarding Measure #158 Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy, expressing concern that there is no reliable data, controlled or otherwise, that shows that use of patch graft results in better outcomes.

Finally, one commenter suggested that the following proposed 2010 measures selected from the 2009 PQRI quality measure set available for either claims-based reporting or registry-based reporting may not promote quality care because they do not adequately address concerns of patient groups that rely on plasma derived treatments such as those with primary immune deficiency or alpha-1 antitrypsin deficiency:

- Measure #51 Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation;
- Measure #64 Asthma: Asthma Assessment;
- Measure #65 Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Use;
- Measure #110 Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old; and
- Measure #126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy—Neurological Evaluation.

The commenter suggested that we focus on aligning these measures with accepted clinical practices for patients that rely on plasma-derived treatments.

Response: Health care quality measures are currently developed by a variety of organizations and used by a variety of governmental and nongovernmental, and public-private initiatives which have various and at times differing priorities and programmatic needs for quality measures. As reflected by the considerations for identifying proposed PQRI quality measures described above, we are committed to having a broad and robust set of quality measures for the PQRI. However, we largely depend on the development of measures by professional organizations and other measure developers. Although we had significant involvement in the development of measures applicable to eligible professionals at the start of the PQRI, currently we are not directly involved in the development of clinician-level quality measures for PQRI, but do select from measures that meet the statutory requirements and other considerations described above.

Quality measures that have completed the consensus processes of NQF or AQA have a designated party (generally the measure developer/owner) who has accepted responsibility for maintaining the measure. In general, it is the role of the measure owner, developer, or maintainer to make substantive changes to a measure, including any updates to the measure to reflect the current clinical evidence such as the changes suggested by the commenters above. The measure maintainer and/or the developer/owner of a measure included in the final set of quality measures selected for the 2010 PQRI is identified as the ''Measure Developer'' in Tables 11 through 28. In addition, NQF has, for its endorsed measures, an established maintenance process which may be accessed. The Secretary is required to provide opportunities for public comment on selected measures and do so through notice and comment rulemaking. We do not, however, use notice and comment rulemaking as a means to update or modify measure specifications. We retain the ability to update or modify specifications to the measures until December 31, 2009.

After that date, there will be no changes to the measure for the 2010 reporting period(s).

Comment: One commenter was concerned about the potential retention of claims-based reporting for Measure #124 Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR). The commenter assumes that if an eligible professional had an EHR, he or she would be able to submit this type of data directly from the EHR rather through claims. This also appears to conflict with the statement that Measure #124 is proposed to be an EHR measure. The commenter requests further clarification.

Response: As reflected in Tables 11 and 14, Measure #124 is available for reporting via claims, a qualified registry, or a qualified EHR for the 2010 PQRI. We decided to continue to allow eligible professionals to report Measure #124 via claims for the 2010 PQRI because we do not anticipate that there will be a sufficient number of qualified EHR vendors for the 2010 PQRI to permit a majority of those who adopt and use an EHR to report this measure via their EHR.

Comment: One commenter supported the proposal that Measure #46 Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility would be available for claims and registry reporting since registries reported difficulty capturing the required information for the 2009 PQRI.

Response: We agree. As such, Measure #46 is listed in Table 11 as a measure that is available for claims and registry reporting in the 2010 PQRI.

Comment: With respect to Measure #52 Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy, one commenter pointed out that Medicare DMERC coverage criteria for LABA are not consistent with clinical guidelines.

Response: Medicare coverage policy is beyond the scope of this section of the final rule. Questions or concerns about Medicare coverage policy should be directed to *CMS_caginquiries@cms.hhs.gov.*

For the reasons discussed above and based on the comments received, we are finalizing in the 2010 PQRI quality measure set the 116 2009 PQRI measures that were proposed to be available in the 2010 PQRI for claims and registry reporting identified in Table 11. In addition, Table 11 includes 1 2009 PQRI measure that was proposed for retirement in 2010 and 2 2009 PQRI measures that were proposed to be available for registry reporting only (see sections II.G.2.i. and II.G.2.i.2., respectively, of this final rule for further details). The 119 individual 2009 PQRI measures selected for inclusion in the 2010 PQRI quality measure set as individual quality measures for either claims-based reporting or registry-based reporting are listed by their Measure Number and Title in Table 11, along with the name of the measure's developer/owner. The PQRI Measure Number is a unique identifier assigned by CMS to all measures in the PQRI measure set. Once a PQRI Measure Number is assigned to a measure, it will not be used again to identify a different measure, even if the original measure to which the number was assigned is subsequently retired from the PQRI measure set. A description of the measures listed in Table 11 can be found in the ''2009 PQRI Quality Measures List,'' which is available on the Measures and Codes page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.*

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TABLE 11: 2010 Measures Selected From the 2009 PQRI Quality Measure Set Available for Either Claims-based Reporting or Registry-based Reporting

Measure Number	Measure Title	Measure Developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	NCQA
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	NCQA
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	NCQA
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	AMA-PCPI
9	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD	NCQA
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports	AMA-PCPI/NCQA
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	AMA-PCPI/NCQA
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	AMA-PCPI/NCQA
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	AMA-PCPI/NCQA
19	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care	AMA-PCPI/NCQA
20	Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician	AMA-PCPI/NCQA
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	AMA-PCPI/NCQA
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	AMA-PCPI/NCQA
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	AMA-PCPI/NCQA

Measure Number	Measure Title	Measure Developer
24	Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	AMA-PCPI/NCQA
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI)	AMA-PCPI/NCQA
30	Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics	AMA-PCPI/NCQA
31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage	AMA-PCPI/NCQA
32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	AMA-PCPI/NCQA
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	AMA-PCPI/NCQA
36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	AMA-PCPI/NCQA
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	AMA-PCPI/NCQA
40	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	AMA-PCPI/NCQA
41	Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older	AMA-PCPI/NCQA
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	Society of Thoracic Surgeons (STS)
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	STS
45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	AMA-PCPI/NCQA
46	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	AMA-PCPI/NCQA
47	Advance Care Plan	AMA-PCPI/NCQA

Measure Number	Measure Title	Measure Developer
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA
49	Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	AMA-PCPI
52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	AMA-PCPI
53	Asthma: Pharmacologic Therapy	AMA-PCPI
54	12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	AMA-PCPI/NCQA
55	12-Lead Electrocardiogram (ECG) Performed for Syncope	AMA-PCPI/NCQA
56	Community-Acquired Pneumonia (CAP): Vital Signs	AMA-PCPI/NCQA
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	AMA-PCPI/NCQA
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status	AMA-PCPI/NCQA
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic	AMA-PCPI/NCQA
64	Asthma: Asthma Assessment	AMA-PCPI
65	Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Use	NCQA
66	Appropriate Testing for Children with Pharyngitis	NCQA
67	Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow	AMA-PCPI/American Society of Hematology (ASH)
68	Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	AMA-PCPI/ASH

Measure Number	Measure Title	Measure Developer
69	Multiple Myeloma: Treatment with Bisphosphonates	AMA-PCPI/ASH
70	Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	AMA-PCPI/ASH
71	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	AMA-PCPI/American Society of Clinical Oncology (ASCO)/National Comprehensive Cancer Network (NCCN)
72	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	AMA-PCPI/ASCO/NCCN
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol	AMA-PCPI
79	End-Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD	AMA-PCPI
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment	AMA-PCPI
85	Hepatitis C: HCV Genotype Testing Prior to Treatment	AMA-PCPI
86	Hepatitis C: Antiviral Treatment Prescribed	AMA-PCPI
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment	AMA-PCPI
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	AMA-PCPI
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy	AMA-PCPI
91	Acute Otitis Externa (ACE): Topical Therapy	AMA-PCPI
92	Acute Otitis Externa (ACE): Pain Assessment	AMA-PCPI
93	Acute Otitis Externa (ACE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	AMA-PCPI

Measure Number	Measure Title	Measure Developer
94	Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility	AMA-PCPI
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	AMA-PCPI/College of American Pathologists (CAP)
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grace	AMA-PCPI/CAP
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients	AMA-PCPI
104	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients	AMA-PCPI
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy	AMA-PCPI
106	Major Depressive Disorder (MDD): Diagnostic Evaluation	AMA-PCPI
107	Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	NCQA
109	Osteoarthritis: Function and Pain Assessment	AMA-PCPI
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	AMA-PCPI
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	NCQA
112	Preventive Care and Screening: Screening Mammography	NCQA
113	Preventive Care and Screening: Colorectal Cancer Screening	NCQA
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	AMA-PCPI
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit	NCQA

Measure Number	Measure Title	Measure Developer
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	NCQA
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	NCQA
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	NCQA
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorous, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	AMA-PCPI
122	Chronic Kidney Disease (CKD): Blood Pressure Management	AMA-PCPI
123	Chronic Kidney Disease (CKD): Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	AMA-PCPI
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	CMS/Quality Insights of Pennsylvania (QIP)
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	American Podiatric Medical Association (APMA)
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	APMA
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS/QIP
130	Documentation and Verification of Current Medications in the Medical Record	CMS/QIP
131	Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up	CMS/QIP
134	Screening for Clinical Depression and Follow-Up Plan	CMS/QIP
135	Chronic Kidney Disease (CKD): Influenza Immunization	AMA-PCPI
139	Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement	AMA-PCPI/NCQA

Measure Number	Measure Title	Measure Developer
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	AMA-PCPI/NCQA
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of Plan of Care	AMA-PCPI/NCQA
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications	AMA-PCPI
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	AMA-PCPI/NCQA
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	AMA-PCPI/NCQA
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	AMA-PCPI
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	AMA-PCPI
154	Falls: Risk Assessment	AMA-PCPI/NCQA
155	Falls: Plan of Care	AMA-PCPI/NCQA
156	Oncology: Radiation Dose Limits to Normal Tissues	AMA-PCPI
157	Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection	STS
158	Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy	Society of Vascular Surgeons (SVS)
163	Diabetes Mellitus: Foot Exam	NCQA
172	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula	SVS
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening	AMA-PCPI
175	Pediatric End-Stage Renal Disease (ESRD): Influenza Immunization	AMA-PCPI
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	AMA-PCPI/NCQA

Measure Number	Measure Title	Measure Developer
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	AMA-PCPI/NCQA
178	Rheumatoid Arthritis (RA): Functional Status Assessment	AMA-PCPI/NCQA
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	AMA-PCPI/NCQA
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	AMA-PCPI/NCQA
181	Elder Maltreatment Screen and Follow-Up Plan	CMS/QIP
182	Functional Outcome Assessment in Chiropractic Care	CMS/QIP
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV	AMA-PCPI
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV	AMA-PCPI
185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	AMA-PCPI/NCQA
186	Wound Care: Use of Compression System in Patients with Venous Ulcers	AMA-PCPI/NCQA

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Please note that detailed measure specifications, including the measure's title, for 2009 individual PQRI quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2010. The 2010 PQRI quality measure specifications for any given individual quality measure may, therefore, be different from specifications for the same quality measure used for 2009. Specifications for all 2010 individual PQRI quality measures, whether or not included in the 2009 PQRI program, must be obtained from the specifications document for 2010 individual PQRI quality measures, which will be available on the PQRI section of the CMS Web site on or before December 31, 2009.

(2) 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Registry-Based Reporting Only

We proposed to select 26 registry-only individual measures from the 2009 PQRI for the 2010 PQRI (74 FR 33579 through 33580). Nine of the 26 proposed measures were previously available for either claims-based reporting or registry-based reporting. We solicited comments on our proposal to increase the number of registry-only measures for the 2010 PQRI.

The following is a summary of the comments received on the 26 proposed registry-only measures.

Comment: We received one comment in support of the following registry-only measures:

- Measure #136 Melanoma: Follow-Up Aspects of Care;
- Measure #137 Melanoma: Continuity of Care—Recall System; and
- Measure #138 Melanoma: Coordination of Care.

Response: We appreciate the commenters' positive feedback. These final measures are listed in Table 12 as 2009 PQRI measures selected for the 2010 PQRI available for registry reporting only.

Comment: We received several comments regarding the proposed reporting mechanism(s) available for proposed 2010 measures. There were several recommendations that the following 2009 PQRI quality measures, which were available for claims or registry reporting in the 2009 PQRI, should not be limited to registry reporting for the 2010 PQRI:

- Measure #83 Hepatitis C: Testing for Chronic Hepatitis C—Confirmation of Hepatitis C Viremia;
- Measure #136 Melanoma: Follow-Up Aspects of Care;
- Measure #137 Melanoma: Continuity of Care—Recall System;
- Measure #138 Melanoma: Coordination of Care;
- Measure #139 Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement; and
- Measure #141 Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15 percent OR Documentation of a Plan of Care.

The primary reason cited by commenters for opposing limiting certain measures to registry reporting is the lack of an available registry.

Response: With respect to the limited availability of registries for certain eligible professionals, we reiterate that there are qualified registries in our 2009 PQRI program that do report all of the PQRI measures. These registries are accepting eligible professionals who wish to sign up as new clients of the

registry. While we acknowledge that there may be costs associated with participating through registries, we note that the decision to participate via a registry is voluntary.

We do, however, agree with commenters' concerns about limiting Measures #139 and #141 to registry reporting. These measures were first introduced in the PQRI quality measure set for the 2009 PQRI and are currently available for claims and registry reporting for 2009. Keeping these measures as measures available for claims and registry reporting for 2010 will allow us to collect more data to analyze the measures' feasibility via claims reporting. Therefore, the measures are listed in Table 11 of this final rule with comment period as 2009 PQRI measures selected for the 2010 PQRI that are available for registry and claims reporting.

Comment: Some commenters were specifically opposed to continuing to limit Measure #174 Pediatric End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis to registry reporting for the 2010 PQRI. Specifically, the commenters suggested that CMS permit claims-based reporting of the measure for 2010 since there are only two pediatric ESRD measures included in PQRI for 2010. One of the pediatric ESRD measures, Measure #175 Pediatric ESRD Influenza Immunization Measure, was proposed to be available for either claims or registry reporting. Because eligible professionals must report on at least 3 measures when using the registry-based reporting mechanism, the commenter felt that making Measure #174 registry only will exclude pediatric nephrologists from participating in the PQRI. In addition, a registry is not available for pediatricians who participate in small academic departments.

Response: The commenter is correct in that eligible professionals who wish to have a qualified registry submit PQRI measure results and numerator and denominator data on PQRI quality measures are required to report at least 3 PQRI quality measures when reporting on individual quality measures or to report all measures in at least 1 measure group when reporting on measure groups. Measure #174 Pediatric End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis was registry only for 2009 PQRI. Due to complexities surrounding the timing of the expected quality action (once per month) this measure will remain registry only for the 2010 PQRI.

However, in response to the commenters' concern that there are only 2 2010 PQRI measures that apply to pediatric nephrologists and only 1 of them (that is, Measure #175) is available for claims-based reporting, eligible professionals who have fewer than 3 applicable measures can still participate in the 2010 PQRI via claims. Such eligible professionals would need to report on all applicable measures that are available for claims-based reporting via claims and meet the appropriate criteria for satisfactory reporting of individual measures in order to qualify for a 2010 PQRI incentive payment.

For the reasons discussed above and based on the comments received, we are finalizing in the 2010 PQRI quality measure set 24 of the 26 proposed 2009 PQRI measures identified in Table 18 of the proposed rule for registry reporting only. As stated above, 2 of the 26 2009 PQRI measures that were proposed to be available for registry reporting only for the 2010 PQRI (that is, Measure #139 and Measure #141), will be available for both registry and claims reporting in the 2010 PQRI and are listed in Table 11 of this final rule with comment period. In addition, we are also retaining 2 2009 PQRI measures that were proposed for retirement for 2010, but we are limiting reporting of these measures to registry reporting for the 2010 PQRI. The 26 2009 PQRI measures selected for the 2010 PQRI that are available for registry reporting only are listed in Table 12 of this final rule with comment period. The 26 individual 2009 PQRI measures selected for inclusion in the 2010 PQRI quality measure set as individual quality measures for registry-based reporting only are listed by their Measure Number and Title in Table 12, along with the name of the measure's developer/owner. A description of the measures listed in Table 12 can be found in the ''2009 PQRI Quality Measures List,'' which is available on the Measures and Codes page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.* Measures that were available for either claims-based reporting or registry-based reporting in the 2009 PQRI but are available for registry-based reporting only in the 2010 PQRI are identified by an asterisk (*) in Table 12.

TABLE 12—2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR REGISTRY-BASED REPORTING ONLY

Measure Number	Measure title	Measure developer
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)*.	AMA–PCPI
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	AMA–PCPI
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)*.	AMA–PCPI
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge.	AMA–PCPI/NCQA
81	End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients.	AMA–PCPI
82	End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis.	AMA–PCPI
83	Hepatitis C: Testing for Chronic Hepatitis C—Confirmation of Hepatitis C Viremia*.	AMA–PCPI
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LSVD)*.	AMA–PCPI
136	Melanoma: Follow-Up Aspects of Care*	AMA–PCPI/NCQA
137	Melanoma: Continuity of Care—Recall System*	AMA–PCPI/NCQA
138	Melanoma: Coordination of Care*	AMA–PCPI/NCQA

TABLE 12—2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR REGISTRY-BASED REPORTING ONLY—Continued

Measure Number	Measure title	Measure developer
143	Oncology: Medical and Radiation—Pain Intensity Quantified*.	AMA–PCPI
144	Oncology: Medical and Radiation—Plan of Care for Pain*	AMA–PCPI
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	AMA–PCPI/NCQA
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis.	AMA–PCPI/NCQA
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy.	AMA–PCPI/NCQA
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy.	AMA–PCPI/NCQA
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation).	STS
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate.	STS
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA).	STS
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency.	STS
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration.	STS
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge.	STS
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge.	STS
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling.	STS
174	Pediatric End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis.	AMA–PCPI

* Individual 2009 PQRI measures that were available for both claims-based and registry-based reporting but will be available for registry-based reporting only for the 2010 PQRI.

Although we are designating certain measures as registry-only measures, we cannot guarantee that there will be a registry qualified to submit each registry-only measure for 2010. We rely on registries to self-nominate and identify the types of measures for which they would like to be qualified to submit quality measures results and numerator and denominator data on quality measures. If no registry self-nominates to submit measure results and numerator and denominator data on a particular type of measure for 2010, then an eligible professional would not be able to report that particular measure type.

We note also that detailed measure specifications, including a measure's title, for 2009 PQRI quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2010. Therefore, the 2010 PQRI quality measure specifications for any given quality measure may be different from specifications for the same quality measure used for 2009. Specifications for all 2010 individual PQRI quality measures, whether or not included in the 2009 PQRI program, must be obtained from the specifications document for 2010 individual PQRI quality measures, which will be available on the PQRI section of the CMS Web site on or before December 31, 2009.

(3) New Individual Quality Measures Selected for 2010

We proposed to include in the 2010 PQRI quality measure set 30 measures that were not included in the 2009 PQRI quality measures provided that each measure obtains NQF endorsement by July 1, 2009 and its detailed specifications are completed and ready for implementation in PQRI by August 15, 2009. Besides having NQF endorsement, we proposed that the development of a measure is considered complete for the purposes of the 2010 PQRI if by August 15, 2009—(1) the final, detailed specifications for use in data collection for PQRI have been completed and are ready for implementation, and (2) all of the Category II Current Procedural Terminology (CPT II) codes required for the measure have been established and will be effective for CMS claims data submission on or before January 1, 2010.

Due to the complexity of their measure specifications, we proposed that 24 of these 30 measures would be available as registry-only measures for the 2010 PQRI. The remaining 6 measures were proposed to be available for reporting through either claims-based reporting or registry-based reporting.

The following is a summary of the comments received on the 30 new individual quality measures proposed for 2010.

Comment: We received numerous comments in support of the proposed additional quality measures for 2010 PQRI. Several commenters stated that these measures ''continue to build upon potential gaps that exist in the prevention and management of chronic conditions.'' One commenter was pleased to see the use of evidence-based clinical quality measures in the 2010 PQRI proposed measures. Comments were received specifically in support of the following measures:

- Functional Communication—Spoken Language Comprehension;
- Functional Communication—Attention;
- Functional Communication—Memory;
- Functional Communication—Motor Speech;
- Functional Communication—Reading;
- Functional Communication—Spoken Language Expression;
- Functional Communication—Writing;

• Functional Communication—Swallowing;
• Perioperative Temperature Management;
• Oncology: Cancer Stage Documented;
• Cataracts: 20/40 or Better Visual Acuity within 90 days following Cataract Surgery;
• Cataracts: Complications within 30 days following Cataract Surgery requiring Additional Surgical;
• Ischemic Vascular Disease (IVD): Blood Pressure Management Control;
• Stenosis Management in Cardiac Imaging Studies;
• Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear;
• Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear within the Previous 90 days;
• Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss;
• Coronary Artery Disease (CAD): Symptom and Activity Assessment;
• Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL–Cholesterol;
• Heart Failure: Left Ventricular Function (LVF) Assessment;
• Heart Failure: Patient Education; and
• Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation.

Response: We appreciate the commenters' support and are finalizing all of the 30 proposed new measures, which are identified in Table 13 of this final rule with comment period.

Comment: We received many comments opposed to limiting one or more new measures proposed for the 2010 PQRI to registry reporting, including the 2 new proposed cataract measures and the 11 new proposed cardiology measures. The commenters suggested that the measures be available for both claims-based and registry reporting for the 2010 PQRI so that practices may choose the best reporting option for them. One commenter also remarked that we should resolve any analytic reporting difficulties with claims-based reporting of these measures internally and not place the burden on eligible professionals.

Response: While we proposed that 19 of the 30 proposed new measures would be available for registry reporting only for 2010 PQRI, we agree, after consideration of the comments received, that it would be feasible to make some of these measures available for either claims or registry reporting. Therefore, the following measures originally proposed for registry only reporting will be available for either claims or registry reporting for the 2010 PQRI:

• Ischemic Vascular Disease (IVD): Blood Pressure Management Control.
• Ischemic Vascular Disease (IVD): Complete Lipid Profile.
• Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL–C) Control.
• Ischemic Vascular Disease (IVD): Use of Aspirin or Another Anti-Thrombotic.

The measure specifications developed by the measure developer for the remaining 15 measures are too complex for claims-based reporting.

Based on the reasons discussed above and comments received, we are finalizing in the 2010 PQRI quality measure set all of 30 proposed 2010 PQRI measures identified in Table 19 of the proposed rule. Please note that 4 measures that were proposed to be available for registry only will be made available for either registry or claims reporting in the 2010 PQRI. These measures are:

• Ischemic Vascular Disease (IVD): Blood Pressure Management Control;
• Ischemic Vascular Disease (IVD): Complete Lipid Profile;
• Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL–C) Control; and
• Ischemic Vascular Disease (IVD): Use of Aspirin or Another Anti-Thrombotic.

The titles of the 30 additional, or new, PQRI measures for 2010 are listed in Table 13 along with the name of the measure developer and the reporting mechanism(s) available (that is, whether the measure will be reportable using claims, registries, or both).

TABLE 13—NEW INDIVIDUAL QUALITY MEASURES SELECTED FOR 2010

Measure title	NQF Endorsement status as of 5/1/09	AQA Adoption status as of 1/31/09	Measure developer	Reporting mechanism(s)
Stroke and Stroke Rehabilitation: Thrombolytic Therapy.	Yes	No	American Heart Association (AHA)/American Stroke Association (ASA).	Registry.
Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear.	Pending NQF review	No	Audiology Quality Consortium (AQC).	Claims, Registry.
Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear within the Previous 90 days.	Pending NQF review	No	AQC	Claims, Registry.
Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss.	Pending NQF review	No	AQC	Claims, Registry.
Cataracts: 20/40 or Better Visual Acuity within 90 days Following Cataract Surgery.	Pending NQF review	Yes	AMA–PCPI/NCQA	Registry.
Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures.	Pending NQF review	Yes	AMA–PCPI/NCQA	Registry.
Perioperative Temperature Management	Yes	Yes	AMA–PCPI	Claims, Registry.
Oncology: Cancer Stage Documented	Yes	Yes	AMA–PCPI/ASCO	Claims, Registry.
Stenosis Measurement in Carotid Imaging Studies.	Yes	Yes	AMA–PCPI/NCQA	Claims, Registry.
Coronary Artery Disease (CAD): Symptom and Activity Assessment.	Yes	No	AMA–PCPI	Registry.
Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol.	Yes	No	AMA–PCPI	Registry.

TABLE 13—NEW INDIVIDUAL QUALITY MEASURES SELECTED FOR 2010—Continued

Measure title	NQF Endorsement status as of 5/1/09	AQA Adoption status as of 1/31/09	Measure developer	Reporting mechanism(s)
Heart Failure: Left Ventricular Function (LVF) Assessment.	Yes	No	AMA–PCPI	Registry.
Heart Failure: Patient Education	Yes	No	AMA–PCPI	Registry.
Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation.	Yes	No	AMA–PCPI	Registry.
Ischemic Vascular Disease (IVD): Blood Pressure Management Control.	Yes	No	NCQA	Claims, Registry.
Ischemic Vascular Disease (IVD): Complete Lipid Profile.	Yes	No	NCQA	Claims, Registry.
Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL–C) Control.	Yes	No	NCQA	Claims, Registry.
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Anti-thrombotic.	Yes	No	NCQA	Claims, Registry.
HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea.	Yes	No	AMA–PCPI/NCQA	Registry.
HIV/AIDS: Screening for High Risk Sexual Behaviors.	Yes	No	AMA–PCPI/NCQA	Registry.
HIV/AIDS: Screening for Injection Drug Use	Yes	No	AMA–PCPI/NCQA	Registry.
HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis.	Yes	No	AMA–PCPI/NCQA	Registry.
Functional Communication Measure—Spoken Language Comprehension.	Yes	No	American Speech Language Hearing Association (ASHA).	Registry.
Functional Communication Measure—Attention.	Yes	No	ASHA	Registry.
Functional Communication Measure—Memory.	Yes	No	ASHA	Registry.
Functional Communication Measure—Motor Speech.	Yes	No	ASHA	Registry.
Functional Communication Measure—Reading.	Yes	No	ASHA	Registry.
Functional Communication Measure—Spoken Language Expression.	Yes	No	ASHA	Registry.
Functional Communication Measure—Writing	Yes	No	ASHA	Registry.
Functional Communication Measure—Swallowing.	Yes	No	ASHA	Registry.

We note also that we are finalizing the following new measures for the 2010 PQRI even though they are still pending NQF endorsement and were not AQA adopted as of January 31, 2009:

- Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear;
- Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear within the Previous 90 days; and
- Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss. As stated above, we are exercising our exception authority under section 1848(k)(2)(C)(ii) of the Act due to the lack of available measures for audiologists. Measures for audiologists represent a specific area for which there are a dearth of measures that have been endorsed by the NQF and/or adopted by the AQA.

(4) 2010 Individual Quality Measures Available for EHR-Based Reporting

We proposed to accept PQRI data from EHRs for a limited subset (10) of the proposed 2010 PQRI quality measures, contingent upon the successful completion of our 2009 EHR data submission testing process and a determination that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible (74 FR 33582).

The following is a summary of the comments received on the proposed electronic submission of these 10 measures.

Comment: One commenter requested that the 2010 EHR measure specifications be released in an expedited fashion so that vendors may properly configure their software in time for the 2010 PQRI.

Response: We agree with the commenter that vendors need sufficient time to adapt their products to support EHR-based capture and submission of data for PQRI measures. To that end, the specifications for the electronic transmission of 2010 PQRI measures were posted on the QualityNet Web site in April 2009 and were updated and reposted in July and September 2009 on the Alternative Reporting Mechanisms page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/20_Alternative ReportingMechanisms.asp#TopOfPage.*

We should note that only eligible professionals using EHR systems that have been ''qualified'' by CMS by virtue of passing our self-nomination and testing process will be able to report their quality data to CMS via their EHR.

Comment: Several comments voiced support for EHR-based reporting of Measure #124, Measure #112, and Measure #113. One commenter was disappointed that no measures relevant to oncology were proposed to be available for 2010 PQRI EHR reporting. Another commenter recommended that the new CAD and heart failure measures proposed for 2010 PQRI registry only reporting also be available for EHR reporting for 2010. One commenter recommended that any potential

retooling of measures for reporting through EHRs should not undermine the scientific basis of the measure.

Response: We appreciate the commenters' support for EHR-based reporting of measures. However, the number of measures available for EHR reporting is limited because in order for measures to be available for EHR-based reporting, measure specifications for the electronic reporting of those measures must be available. We will consider adding new measures for future PQRI program years as specifications become available. The retooling of measures will not change the intent of the measure. We believe that all PQRI measures are evidence-based and consistent with standards of care.

Comment: One commenter suggested that increasing the number of PQRI measures is discriminatory to those that cannot or have not incorporated electronic prescribing due to expense of initiating EHRs and electronic prescribing for small provider offices.

Response: With respect to practices that have not implemented technology that would allow for participation in PQRI via an EHR, there are other 2010 PQRI reporting options available for such practices. There are a total of 125 individual quality measures available for claims or registry reporting for the 2010 PQRI. In addition, 8 of the 13 2010 PQRI measures groups are available for claims or registry reporting (see section II.G.2.i.5. of this final rule with comment period for discussion of the final 2010 PQRI measures groups). The remaining 50 individual PQRI quality measures and 4 measures groups are available for registry reporting in 2010.

With respect to practices that have not implemented technology that would allow for electronic prescribing, we reiterate that the E-Prescribing Incentive Program is a separate and distinct incentive program for eligible professionals. Participation in the E-Prescribing Incentive Program is voluntary and is not required for participation in the 2010 PQRI. Details of the 2010 E-Prescribing Incentive Program can be found in section II.G.5. of this final rule with comment period.

Based on the reasons discussed above and the comments received, we are finalizing the option of accepting clinical quality data extracted from qualified EHRs on all 10 of the proposed 2010 PQRI quality measures identified in Table 20 of the proposed rule. The final 2010 measures available for EHR-based reporting are identified in Table 14 of this final rule with comment period.

TABLE 14—2010 MEASURES AVAILABLE FOR EHR-BASED REPORTING

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	Yes	Yes	NCQA
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus.	Yes	Yes	NCQA
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	Yes	No	NCQA
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Yes	Yes	AMA–PCPI
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	Yes	Yes	AMA–PCPI
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old.	Yes	No	AMA–PCPI
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	Yes	Yes	NCQA
112	Preventive Care and Screening: Screening Mammography	Yes	Yes	NCQA
113	Preventive Care and Screening: Colorectal Cancer Screening	Yes	Yes	NCQA
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR).	Yes	Yes	CMS/QIP

(5) Measures Selected for Inclusion in 2010 Measures Groups

We proposed to retain the 7 2009 PQRI measures groups for the 2010 PQRI: (1) Diabetes Mellitus; (2) CKD; (3) Preventive Care; (4) CABG; (5) Rheumatoid Arthritis; (6) Perioperative Care; and (7) Back Pain (74 FR 33582 through 33587). As in 2009, we proposed the CABG measures group would be reportable through the registry-based reporting mechanism only for 2010 while the remaining 6 2009 PQRI measures groups would be reportable through either claims-based reporting or registry-based reporting for the 2010 PQRI.

In addition to the 7 measures groups that we proposed to retain from the 2009 PQRI, we proposed 6 new measures groups for the 2010 PQRI, for a total of 13 CY 2010 measures groups. The 6 new measures groups proposed for the 2010 PQRI were: (1) Coronary Artery Disease (CAD); (2) Heart Failure; (3) Ischemic Vascular Disease (IVD); (4) Hepatitis C; (5) Human Immunodeficiency Virus (HIV)/ Acquired Immune Deficiency Syndrome (AIDS); and (6) Community Acquired Pneumonia (CAP). Since many of the 6 new measures groups proposed for 2010 contained proposed new registry-only measures, only 8 proposed 2010 measures groups would be reportable through either claims-based reporting or registry-based reporting: Diabetes Mellitus; CKD; Preventive Care; Perioperative Care; Rheumatoid Arthritis; Back Pain; Hepatitis C; and Community Acquired Pneumonia. We solicited comments on our proposal to limit claims-based reporting of measures groups in 2010.

Finally, we also proposed that except for the measures included in the Back Pain measures group, the measures included in any proposed 2010 measures group would be reportable either as individual measures or as part of a measures group. Similar to the 2009 PQRI, we proposed that the measures proposed for inclusion in the Back Pain measures group would be reportable only as part of a measures group and not as individual measures in 2010.

The measures proposed for inclusion in each of the proposed 2010 measures groups were identified in Tables 21 through 33 of the CY 2010 PFS proposed rule (74 FR 33582 through 33587).

The following is a summary of the comments received on the proposed 2010 measures groups.

Comment: We received several comments in support of the proposed 2010 PQRI measures groups. Specifically, we received comments in support of the Preventive Care, CAP, HIV/AIDS, Hepatitis C, Rheumatoid Arthritis, IVD, and Heart Failure measures groups. Some commenters also commended CMS for the inclusion of specific measures in certain measures groups.

Response: We appreciate the commenters' feedback. As identified in Tables 15 through 27 of this final rule with comment period, we are finalizing all of the 13 proposed 2010 PQRI measures groups. No changes were made to the measures included in the measures groups. However, as a result of 4 measures proposed for inclusion in the IVD measures group that were proposed to be registry only measures now being available for either claims or registry reporting, the IVD measures group will also be available for either claims or registry reporting.

Comment: Some commenters suggested changes to our definition of ''measures group.'' One commenter urged us to reduce the number of measures required for reporting a measure group to a minimum of 3 measures. Another commenter requested that we define ''measures group'' to be any 3 measures. One commenter recommended that we implement measures groups with complex denominators to allow for reporting on measures that have an associated impact on patient care and positive outcomes.

Response: As stated in the CY 2010 PFS proposed rule (74 FR 33568), ''measures group'' has been previously defined as a subset of 4 or more PQRI measures that have a particular clinical condition or focus in common. The denominator definition and coding of the measures groups identifies the condition or focus that is shared across the measures within a particular measures group. If we change this definition as suggested by commenters, then there would be no difference in terms of reporting measures groups and reporting PQRI individual quality measures since eligible professionals who choose to report on individual PQRI quality measures are already generally required to report on 3 measures. The only exception that permits eligible professionals to report on fewer than 3 measures is when an eligible professional has fewer than 3 applicable measures. For eligible professionals in this situation, the only option is to report applicable measures via claims.

Comment: One commenter recommended that we monitor Measure #115 Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit for the CAD measures group for ''appropriate conclusion as more evidence is released which will show whether advising smokers to quit increases the chances that they actually will quit.''

Response: We assume that that the commenter is requesting that we monitor Measure #115 for appropriate inclusion in CAD the measures groups. As with all measures and measures groups selected for inclusion in the PQRI quality measure set, we will continue to monitor the appropriateness of including Measure #115 in the CAD measures group on an ongoing basis for future program years.

Comment: One commenter recommended that claims-based reporting be available for all measures groups. Other commenters recommended that claims-based reporting be available for specific measures groups, such as the CAD, IVD, Heart Failure, HIV/AIDS measures groups.

Response: The following 2010 PQRI measures groups will be reportable only via registry-based reporting: (1) CABG; (2) CAD; (3) Heart Failure; and (4) HIV/AIDS. These measures groups will be registry-only because they include individual 2010 PQRI registry-only measures that cannot be feasibly specified for claims based reporting.

Although we proposed that the IVD measures group would also be registry-only for 2010, we determined, based on comments that it is feasible to make the proposed registry-only measures proposed for inclusion in the IVD measures group available for either claims or registry reporting for 2010. Therefore, the IVD measures group will be available for either claims or registry reporting.

Comment: Some commenters recommended the addition of specific codes to particular measures that were proposed for inclusion in a measures group. Specifically, one commenter recommended the addition of 2 physical therapy codes to the back pain measures for the proposed Back Pain measures group. Another commenter recommended the addition of inpatient codes for the measures proposed for inclusion in the CAP measures group.

Response: As stated previously, it is generally the role of the measure owner, developer, or maintainer to make substantive changes to a measure. The addition of physical therapy codes would mean that it is appropriate to hold such professionals accountable for the measure, which we believe constitutes such a substantive issue. The measure maintainer and/or the developer/owner of a measure included in the final set of 2010 PQRI measures groups is identified as the ''Measure Developer'' in Tables 15 through 27 of this final rule with comment period. In addition, NQF has, for its endorsed measures, an established maintenance process which may be accessed. Both venues would be available to seek such substantive changes to the measures. Although we are required by section 1848(k)(2)(D) of the Act to give the public an opportunity to provide input on the selection of PQRI measures and do so via notice and comment rulemaking, we do not use notice and comment rulemaking as a means to make substantive changes to measures nor to update or modify measure specifications. We retain the ability to update or modify specifications to the measures until December 31, 2009. After that date, there will be no changes to the measure for the 2010 reporting period(s).

Based on the reasons discussed above and comments received, we are finalizing the following proposed 2010 measures groups: (1) Diabetes Mellitus; (2) CKD; (3) Preventive Care; (4) CABG; (5) Rheumatoid Arthritis; (6) Perioperative Care; (7) Back Pain; (8) CAD; (9) Heart Failure; (10) IVD; (11) Hepatitis C; (12) HIV/AIDS; and (13) CAP. The following 4 measures groups are reportable through the registry-based reporting mechanism only: (1) CABG; (2) CAD; (3) Heart Failure; and (4) HIV/AIDS. The IVD measures group is no longer limited to registry only reporting since 4 measures included in the group that were proposed to be registry-only measures are now available for either claims or registry reporting for 2010 (see section II.G.2.i.2. above).

The measures selected for inclusion in each of the 2010 measures groups are identified in Tables 15 through 27 of this final rule with comment period. Some measures selected for inclusion in these 6 measures group are current 2009 individual PQRI measures. The title of each such measure is preceded with its PQRI Measure Number in Tables 15 through 27. As stated previously, the PQRI Measure Number is a unique identifier assigned by CMS to all measures in the PQRI measure set. Once a PQRI Measure Number is assigned to a measure, it will not be used again, even if the measure is subsequently retired from the PQRI measure set. Measures that are not preceded by a number (in other words, those preceded

by "TBD") in Tables 15 through 27 were never part of a PQRI measure set prior to 2010. A number will be assigned to such measures for 2010.

In addition, some measures selected for inclusion in some of these measures groups for 2010 were not included in the measures groups in 2009. The 2009 measures selected for inclusion in a 2010 measures group that were not included in the measures group for 2009 are identified with an asterisk (*).

We also note that the proposed 2010 Heart Failure measures group included the measure Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation, which is not included in the final 2010 Heart Failure measures group. The measure does not meet the common denominator criteria for the Heart Failure measures group because it requires an additional denominator code for atrial fibrillation. This additional code is not in the other 7 measures included in the Heart Failure measures group. As stated previously, measures groups must have a particular condition or focus in common, as identified by the denominator definition and coding of the measures group.

As with measures group reporting in the 2008 and 2009 PQRI, each eligible professional electing to report a group of measures for 2010 must report all measures in the group that are applicable to each patient or encounter to which the measures group applies at least up to the minimum number of patients required by the applicable reporting criteria. The measures selected for the Back Pain measures group continue to be reportable only as part of a measures group and not as individual measures for the 2010 PQRI. Measures selected for inclusion in all other 2010 PQRI measures groups are reportable either as individual measures or as part of a measures group.

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TABLE 15: Measures Selected for 2010 Diabetes Mellitus Measures Group

Measure Number	Measure Title	Measure Developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	NCQA
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	NCQA
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	NCQA
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	NCQA
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	NCQA
163	Diabetes Mellitus: Foot Exam	NCQA

TABLE 16: Measures Selected for 2010 CKD Measures Group

Measure Number	Measure Title	Measure Developer
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	AMA-PCPI
122	Chronic Kidney Disease (CKD): Blood Pressure Management	AMA-PCPI
123	Chronic Kidney Disease (CKD): Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	AMA-PCPI
135	Chronic Kidney Disease (CKD): Influenza Immunization	AMA-PCPI
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	AMA-PCPI

TABLE 17: Measures Selected for 2010 Preventive Care Measures Group

Measure Number	Measure Title	Measure Developer
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	AMA-PCPI/NCQA
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	AMA-PCPI/NCQA
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	AMA-PCPI
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	NCQA
112	Preventive Care and Screening: Screening Mammography	NCQA
113	Preventive Care and Screening: Colorectal Cancer Screening	NCQA
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	AMA-PCPI
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit	NCQA
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS/QIP
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening*	AMA-PCPI

*This 2009 PQRI measure was not part of this measures group for 2009, but was selected for inclusion in this measures group for 2010.

TABLE 18: Measures Selected for 2010 CABG Measures Group+

Measure Number	Measure Title	Measure Developer
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	Society of Thoracic Surgeons (STS)
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	STS
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)	STS
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	STS
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)	STS
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency	STS
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration	STS
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	STS
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	STS
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling	STS

+ This measures group is reportable through registry-based reporting only.

TABLE 19: Measures Selected for 2010 Rheumatoid Arthritis Measures Group

Measure Number	Measure Title	Measure Developer
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	NCQA
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	AMA-PCPI/NCQA
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	AMA-PCPI/NCQA
178	Rheumatoid Arthritis (RA): Functional Status Assessment	AMA-PCPI/NCQA
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	AMA-PCPI/NCQA
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	AMA-PCPI/NCQA

TABLE 20: Measures Selected for 2010 Perioperative Care Measures Group

Measure Number	Measure Title	Measure Developer
20	Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician	AMA-PCPI/NCQA
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	AMA-PCPI/NCQA
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	AMA-PCPI/NCQA
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	AMA-PCPI/NCQA

TABLE 21: Measures Selected for 2010 Back Pain Measures Group

Measure Number	Measure Title	Measure Developer
148	Back Pain: Initial Visit	NCQA
149	Back Pain: Physical Exam	NCQA
150	Back Pain: Advice for Normal Activities	NCQA
151	Back Pain: Advice Against Bed Rest	NCQA

TABLE 22: Measures Selected for 2010 CAD Measures Group+

Measure Number	Measure Title	Measure Developer
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	AMA-PCPI
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	AMA-PCPI
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit	NCQA
TBD	Coronary Artery Disease (CAD): Symptom and Activity Assessment	AMA-PCPI
TBD	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	AMA-PCPI

+ This measures group is reportable through registry-based reporting only.

TABLE 23: Measures Selected for 2010 Heart Failure Measures Group+

Measure Number	Measure Title	Measure Developer
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA-PCPI
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	AMA-PCPI
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit	NCQA
TBD	Heart Failure: Left Ventricular Function (LVF) Assessment	AMA-PCPI
TBD	Heart Failure: Patient Education	AMA-PCPI

+ This measures group is reportable through registry-based reporting only.

TABLE 24: Measures Selected for 2010 IVD Measures Group

Measure Number	Measure Title	Measure Developer
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	AMA-PCPI
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit	NCQA
TBD	Ischemic Vascular Disease (IVD): Blood Pressure Management Control	NCQA
TBD	Ischemic Vascular Disease (IVD): Complete Lipid Profile	NCQA
TBD	Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control	NCQA
TBD	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Anti-thrombotic	NCQA

TABLE 25: Measures Selected for 2010 Hepatitis C Measures Group

Measure Number	Measure Title	Measure Developer
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment	AMA-PCPI
85	Hepatitis C: HCV Genotype Testing Prior to Treatment	AMA-PCPI
86	Hepatitis C: Antiviral Treatment Prescribed	AMA-PCPI
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment	AMA-PCPI
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	AMA-PCPI
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy	AMA-PCPI
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV	AMA-PCPI
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV	AMA-PCPI

TABLE 26: Measures Selected for 2010 HIV/AIDS Measures Group+

Measure Number	Measure Title	Measure Developer
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	AMA-PCPI/NCQA
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	AMA-PCPI/NCQA
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	AMA-PCPI/NCQA
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy	AMA-PCPI/NCQA
TBD	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea	AMA-PCPI/NCQA
TBD	HIV/AIDS: Screening for High Risk Sexual Behaviors	AMA-PCPI/NCQA
TBD	HIV/AIDS: Screening for Injection Drug Use	AMA-PCPI/NCQA
TBD	HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis	AMA-PCPI/NCQA

+ This measures group is selected to be reportable through registry-based reporting only.

TABLE 27: Measures Selected for 2010 CAP Measures Group

Measure Number	Measure Title	Measure Developer
56	Community-Acquired Pneumonia (CAP): Vital Signs	AMA-PCPI/NCQA
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	AMA-PCPI/NCQA
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status	AMA-PCPI/NCQA
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic	AMA-PCPI/NCQA

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We note that the specifications for measures groups do not necessarily contain all the specification elements of each individual measure making up the measures group. This is based on the need for a common set of denominator specifications for all the measures making up a measures group in order to define the applicability of the measures group. Therefore, the specifications and instructions for measures groups will be provided separately from the specifications and instructions for the individual 2010 PQRI measures. We will post the detailed specifications and specific instructions for reporting measures groups on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* by no later than December 31, 2008.

Additionally, the detailed measure specifications and instructions for submitting data on those 2010 measures groups that were also included as 2009 PQRI measures groups may be updated or modified prior to 2010. Therefore, the 2010 PQRI measure specifications for any given measures group could be different from specifications and submission instructions for the same measures group used for 2009. These measure specification changes do not materially impact the intended meaning of the measures or the strength of the measures.

(6) Request for Public Comment on Measure Suggestions for Future PQRI Quality Measure Sets

In the CY 2010 PFS proposed rule (74 FR 33587), we invited commenters to submit suggestions for individual quality measures and measures groups (that is, suggestions for new measures groups and/or suggestions for the composition of measures groups) for consideration for possible inclusion in the proposed set of quality measures for use in the 2011 PQRI. We asked individuals or organizations submitting suggestions to provide us with the following information:

- Requestor contact information, such as name and title, organization/practice name, phone number and e-mail address;
- Measure title;
- Measure description;
- Measure owner/developer;
- NQF endorsement status, including the date of endorsement or anticipated endorsement (if not NQF-endorsed) and type of endorsement (for example, time-limited endorsement);
- AQA adoption status, including date of AQA adoption or anticipated AQA adoption;
- Preferred PQRI reporting option for the suggested measure(s) (that is, claims, registry, registry-only, measures group, measures group only, EHRs); and
- The measure specifications.

The following is summary of the comments we received regarding suggestions for individual quality measures and measures groups (that is, suggestions for new measures groups and/or suggestions) for the 2011 PQRI.

Comment: Several commenters suggested quality measures or measures groups for the 2010 PQRI in addition to the quality measures and measures groups for individual eligible professionals we had proposed in Tables 19 through 33 of the CY 2010 PFS proposed rule (74 FR 33575 through 33587).

Response: We have not included in this final rule with comment period for the 2010 PQRI any individual quality measures that were not identified in the CY 2010 PFS proposed rule as proposed 2010 PQRI measures. As discussed above in this final rule with comment period, we are obligated by section 1848(k)(2)(D) of the Act to give eligible professionals an opportunity to provide input during the selection of measures for the 2010 PQRI and subsequent years. Eligible professionals have not had an opportunity to provide input on measures recommended for selection via comments on the proposed rule that were not specifically included in the proposed rule. Thus, such additional measures recommended via comments on the proposed rule cannot be included in the 2010 PQRI quality measure set. However, we have captured these recommendations and will have them available for consideration in identifying measure sets for future years' PQRI and other initiatives to which those measures may be pertinent.

Comment: As we requested in the CY 2010 PFS proposed rule (74 FR 33587), several commenters suggested quality measures or measures groups for the 2011 PQRI.

Response: We have captured these recommendations. To the extent information provided is complete (that is, includes the measure or measure group details requested in the proposed rule), we will consider the commenters' recommendations in identifying measure sets for future years' PQRI and other initiatives to which those measures may be pertinent. As we stated in the CY 2010 PFS proposed rule, suggesting individual measures or measures for new or proposed measures groups does not mean that the measure(s) or measures group(s) will be included in the proposed or final sets of measures or measures groups of any proposed or final rules that address the 2011 PQRI. We will determine what individual measures and measures group to include in the proposed set of quality measures, and after a period of public comment, we will make the final determination with regard to the final set of quality measures for the 2011 PQRI.

Comment: Some commenters urged us to expand the opportunities for measures to be presented to CMS for potential inclusion in the PQRI. One commenter elaborated that the process to develop and endorse measures takes a considerable amount of time and measure developers should have greater opportunities to bring measures forward. The commenter also requested that we review the process by which PQRI measures are selected to ensure transparency and greater communication with measure developers. The commenter stated that currently the process leaves little opportunity for the measure developer to dialogue with CMS if the measure is denied. The commenter believes we should provide feedback on suggested measures prior to publication of the proposed rule.

Response: We understand the commenters' concerns. As stated previously, we largely depend on the development of measures by professional organizations and other measure developers. As such, we depend on the measure developers and other stakeholders to bring forth potential measures to our attention. We are continuing to look for ways to improve the process for allowing stakeholders to bring forth suggested measures and are considering some changes in the process future years PQRI. For example, in addition to our invitation to submit suggestions for measures and measures groups for potential inclusion in the 2011 PQRI contained in CY 2010 PFS proposed rule (74 FR 33587), we are considering a Call for 2011 Measures that will allow stakeholders to submit additional measures and/or measures groups suggestions for the 2011 PQRI after publication of this final rule followed by a listening session in early 2010 to promote a dialogue with stakeholders with respect to the measure or measures group suggestions we receive.

j. 2010 PQRI Quality Measures for Physician Groups Selected To Participate in the Group Practice Reporting Option

We proposed that physician groups selected to participate in the 2010 PQRI group practice reporting option would be required to report on 26 measures (74 FR 33587). These measures are NQF-endorsed measures currently collected

as part of the PGP and/or MCMP demonstrations.

The following is summary of the comments we received regarding the proposed 2010 PQRI Quality Measures for physician groups selected to participate in the PQRI group practice reporting option.

Comment: Some commenters suggested that we broaden the scope of measures so that the measures would be applicable to specialty care such as emergency medicine, gastroenterology, and surgical specialties. A few commenters felt that group practices are being required to report on too many measures. Several commenters believe that it is appropriate for CMS to first implement the group practice reporting option by focusing on the high-cost chronic conditions and preventive care reflected by the proposed measures.

Response: We recognize that the measures largely apply to primary care. However, as required by statute, the measures shall target high-cost chronic conditions and preventive care. This reporting option is for group practices with 200 or more eligible professionals. On average, these group practices typically have 20,000 patients assigned to each group practice. Each group practice will be required to complete the data collection tool on a total of no more than 3,699 consecutively assigned and ranked patients, which is 411 patients per disease module and preventive care measure. Thus, the number of measures is considered to be equitable for practices with this volume of patients and eligible professionals. We will continue to evaluate the number and types of measures and modules for future program years.

Comment: We received some comments in support of the proposed measures for the group practice reporting option. A few commenters expressed support for specific proposed measures, including:

- Measure #1 Diabetes Mellitus: Hemoglobin A1c Poor Control;
- Measure #5 Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD);
- Measure #6 Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD;
- Measure #7 Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI);
- Measure #8 Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD); Measure #118 Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD);
- Heart Failure: Left Ventricular Function (LVF) Testing;
- Heart Failure: Left Ventricular Function (LVF) Assessment;
- Heart Failure: Weight Measurement;
- Heart Failure: Patient Education;
- Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation; and
- Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol.

Response: We appreciate the commenters support. The final measures for physician groups participating in the 2010 PQRI group practice reporting option are identified in Table 28.

Comment: One commenter noted that the 2 proposed hypertension measures (Hypertension (HTN): Blood Pressure Control and Hypertension (HTN): Plan of Care) are not included in the larger list of 2010 PQRI measures for individual eligible professionals. The commenter recommended that we include these 2 measures as 2010 PQRI individual quality measures for individual eligible professionals.

Response: The commenter is correct; these 2 measures are not available to individual eligible professionals to report for the 2010 PQRI. Since these measures were not proposed to be included in the 2010 PQRI quality measure set for individual eligible professionals, however, we are unable to add them to the PQRI quality measure set for individual quality measures for 2010. As stated previously, section 1848(k)(2)(D) of the Act requires us to give the public an opportunity to provide input on the selection of measures for the PQRI, which we accomplish through notice and comment rulemaking. Since these measures have not been placed before the public as potential measures for individual eligible professionals for the 2010 PQRI, eligible professionals and other stakeholders have not had an opportunity to provide input on the inclusion of these 2 measures in the 2010 PQRI quality measure set for individual eligible professionals.

Comment: The measure developer/owner of the Heart Failure: Weight measurement measure requested that we remove the measure from the group reporting option since the measure owner's measure workgroup is planning to retire the measure from its heart failure measure set in the upcoming months.

Response: We value the input of the measure developer/owner. Furthermore, we look to the measure developer/owner to maintain and update measures based on the standards of care and evidence base. We believe, however, that the Heart Failure: Weight Measurement measure targets a high-cost chronic condition. The measure is a valuable measure in the evaluation of patients with heart failure and continues to have a significant impact on the care and improvement in outcomes. Additionally, the measure has undergone the scientific rigor of achieving consensus endorsement by the NQF. Therefore, we will retain this measure, as proposed, in the group practice reporting option. The final measure specifications for the group practice reporting option will be posted on the CMS Web site *http://www.cms.hhs.gov/pqri* no later than December 31, 2009.

Comment: One commenter noted that measure developer listed in the proposed rule for the ''Preventive Care: Blood Pressure Management'' measure was incorrect and should be corrected in the final rule.

Response: The measure title was incorrectly listed as ''Preventive Care: Blood Pressure Management.'' The correct title is ''Hypertension: Blood Pressure Measurement.'' This correction is reflected in Table 28.

Based on the reasons discussed above and after considering the comments, for the 2010 PQRI, group practices selected to participate in the PQRI group practice reporting option will be required to report on all measures listed in Table 28. To the extent that a measure is an existing PQRI measure available for reporting by individual eligible professionals, the Measure Title is preceded by the measure's PQRI Measure Number. If there is no number in the PQRI Measure Number column of the table, then the measure is not an existing PQRI measure and will be added to the 2010 PQRI for purposes of the group practice reporting option.

A separate measures specifications manual and other supporting documents will be available for group practices participating in the 2010 PQRI group practice reporting option. We anticipate that the group practice measures specifications manual will be available by November 15, 2009 on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.*

TABLE 28—MEASURES FOR PHYSICIAN GROUPS PARTICIPATING IN THE 2010 PQRI GROUP PRACTICE REPORTING OPTION

PQRI Measure No.	Measure title	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	NCQA
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control	NCQA
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	NCQA
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	AMA–PCPI
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	AMA–PCPI
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	AMA–PCPI
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	AMA–PCPI
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	AMA–PCPI
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	NCQA
112	Preventive Care and Screening: Screening Mammography	NCQA
113	Preventive Care and Screening: Colorectal Cancer Screening	NCQA/AMA–PCPI
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	NCQA
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD).	AMA–PCPI
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients.	NCQA
163	Diabetes Mellitus: Foot Exam	NCQA
TBD	Diabetes Mellitus: Hemoglobin A1c Testing	NCQA
TBD	Diabetes Mellitus: Lipid Profile	NCQA
TBD	Heart Failure: Left Ventricular Function (LVF) Testing	CMS
TBD	Heart Failure: Left Ventricular Function (LVF) Assessment	AMA–PCPI
TBD	Heart Failure: Weight Measurement	AMA–PCPI
TBD	Heart Failure: Patient Education	AMA–PCPI
TBD	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation	AMA–PCPI
TBD	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL–Cholesterol	AMA–PCPI
TBD	Hypertension: Blood Pressure Measurement	AMA–PCPI
TBD	Hypertension (HTN): Blood Pressure Control	CMS/NCQA
TBD	Hypertension (HTN): Plan of Care	AMA–PCPI

k. Public Reporting of PQRI Data

Section 1848(m)(5)(G) of the Act, as added by the MIPPA, requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submitted data on quality measures for the PQRI and the names of the eligible professionals (or group practices) who are successful electronic prescribers. In accordance with section 1848(m)(5)(G) of the Act, we stated in the CY 2010 PFS proposed rule (74 FR 33588 through 33589) our intent to make public the names of eligible professionals and group practices that satisfactorily submit quality data for the 2010 PQRI on the Physician and Other Health Care Professionals Directory. In addition to posting the information required by section 1848(m)(5)(G) of the Act, for those group practices that are selected to participate in PQRI under the group practice reporting option, we also proposed to make the group practices' PQRI performance rates publicly available, for each of the measures. We solicited comments regarding our proposal to publicly report group practices' PQRI performance results.

The following is summary of the comments we received regarding the public reporting of PQRI data required under section 1848(m)(5)(G)(i) of the Act and our proposal to publicly report group practices' PQRI performance results.

Comment: We received some comments in support of public reporting of either the information required by section 1848(m)(5)(G)(i) of the Act or all PQRI measure results, including individual eligible professionals' performance results. One commenter stated that CMS needs to articulate a clear and aggressive path forward, with short-term benchmarks and a goal of having publicly available, actionable performance and cost information for all participating Medicare clinicians.

Response: We appreciate the commenters' support. As we have stated previously, we believe that public reporting of group practices' PQRI performance results represents an opportunity to make strides towards the goal of being able to make quality information about physicians and other healthcare professionals publicly available.

Comment: One commenter encouraged the use of composite measures to help increase the reliability of individual eligible professionals' performance data.

Response: At this time we have no plans to publicly release individual eligible professionals' performance data. Additional refinements to the PQRI are likely needed as the program matures.

Comment: One commenter recommended that CMS also publicly report the names of eligible professionals who choose not to participate in the PQRI. The commenter stated that the willingness (or lack thereof) of clinicians to participate in performance measurement and reporting should be publicly recognized.

Response: We disagree that such information would be useful to consumers since there are several valid reasons why an eligible professional may choose to not participate in a voluntary initiative, such as the PQRI. Consumers may potentially misinterpret the lack of participation to mean that an eligible professional is not interested in providing quality care.

Comment: Many commenters were opposed to releasing any other data on PQRI until issues with the Physician and Other Health Care Professional Directory are addressed and corrected.

Some of the issues cited by commenters include, the lack of accurate provider listings, poor and difficult to find disclaimer information regarding participation in PQRI, and poor user instructions. Many comments, in particular, requested that the disclaimer that was provided with the list of 2007 PQRI participants be updated and made more prominent.

Response: We appreciate the comments and plan to make improvements to the Directory with respect to reporting PQRI participation.

Comment: Many commenters were opposed to releasing any additional PQRI information, including the information required under section 1848(m)(5)(G)(i) of the Act, because of issues with the PQRI itself. Some of the concerns cited by commenters include the following:

- The errors identified with the 2007 PQRI have compromised the program's validity within the participant community;
- The program's plans to transition away from claims-based reporting may force eligible professionals who satisfactorily reported in the past to stop doing so;
- The potential for consumers to misunderstand the significance of the information being publicly reported since there are still many valid reasons why an eligible professional may not have participated or may have participated but was not considered a satisfactory reporter.

One commenter suggested that we consider alternative data sets for public reporting such as Board certification, CAHPS data, and/or a physician or other health care professional's participation in a registry. Other commenters requested that a formal evaluation of the 2007 and 2008 PQRI be conducted before releasing any participation, reporting, or performance rates.

Response: As required by section 1848(m)(5)(G)(i) of the Act, we must, at a minimum, make public the names of eligible professionals and group practices that satisfactorily submit quality data for the 2010 PQRI on the Physician and Other Health Care Professionals Directory. We anticipate that the names of individual eligible professionals and group practices that satisfactorily submit quality data for the 2010 PQRI will not be made available any earlier than in 2011 after the 2010 incentive payments are paid. In an attempt to address commenters' concerns, we will make information about the intended uses and/or limitations of the information being presented in the form of a disclaimer available on the Web site as well. To the extent that additional information derived from the PQRI, is made public we would also take such concerns into account.

Comment: Several commenters provided recommendations for CMS to consider with respect to publicly reporting PQRI information, including the information required by section 1848(m)(5)(G)(i) of the Act. These suggestions include the following:

- Establishing a process that allows for prior review and comment before data are made public and that allows for any comments received to be included with the publicly reported data;
- Establishing an appeals process with regard to any data that is to be publicly reported;
- Providing information outlining the data's potential uses and limitations;
- Providing information that clearly and specifically states that information about whether an eligible professional is a satisfactory reporter does not necessarily indicate that higher quality care was or will be provided by those eligible professionals (or group practices) who qualified to earn PQRI incentive payments;
- Providing better access to and more timely feedback;
- Avoiding characterization of the names of satisfactory reporters as comparative quality information; and
- Giving eligible professionals an opportunity to explain why they are not participating.

Response: We appreciate the commenters' valuable input. We believe that many of these suggestions have already been addressed. For example, eligible professionals have an opportunity to review their reporting and performance results via the feedback reports that are made available to all participating eligible professionals at the time that incentive payments are released for a particular program year. As discussed previously, we have also created an alternate process to make it easier for eligible professionals to obtain their feedback reports and created a dedicated Help Desk that is available to assist eligible professionals who have any concerns about the information contained in their feedback reports. All information that is publicly reported will also be accompanied by appropriate disclaimers that address the information's potential uses and limitations, including the fact that an eligible professional or group practice is listed as having satisfactorily reported PQRI quality measures does not necessarily indicate that he or she provides higher quality care than those who did not participate or those who participated but did not do so satisfactorily.

Comment: Several commenters provided recommendations for CMS to consider specifically with respect to our proposal to publicly report group practices' PQRI performance results. These suggestions include the following:

- Providing group practices the opportunity to suppress their data;
- Precisely defining what performance data CMS plans to post; and
- Conducting and publishing an evaluation of PQRI on its impact on quality of care before selecting measures for public reporting.

Response: As stated in the CY 2010 PFS proposed rule (74 FR 33589), we proposed to make the group practices' performance rates for each of the PQRI group practice reporting option measures public for each group selected to participate in PQRI group practice reporting option. We proposed to attribute the performance rates to the entire group and will not post any information with respect to the performance of individual eligible professionals other than, potentially, to identify the individual eligible professionals that were associated with the group during the reporting period.

As stated in section II.G.2.g.1. above, however, we have taken the commenters' concerns about publicly reporting the group practices' performance results in the first year of implementation of the PQRI group practice reporting option into consideration. We are not finalizing our proposal to require group practices that wish to utilize the group practice reporting option in 2010 to agree to have their PQRI performance results publicly reported. In addition, we will not report any 2010 group practice performance results publicly at all except as otherwise required by law and will limit public reporting of information on the PQRI group practice reporting to the information required by section 1848(m)(5)(G)(i) of the Act (that is, the names of group practices that satisfactorily submitted data on PQRI quality measures). Instead, we will consider implementing public reporting of group practices' performance results in the 2011 PQRI program year.

Comment: Many commenters were opposed to the public reporting of any PQRI information beyond what is specifically required by section 1848(m)(5)(G)(i) of the Act. These concerns include the following:

- CMS only has the specific authority to publicly report the information

required by section 1848(m)(5)(G)(i) of the Act;

- There continue to be substantial gaps in the PQRI quality measure set that may create a barrier to participation in PQRI;
- The value of PQRI data is questionable since there has been no formal evaluation of the PQRI to determine its impact on the quality of care, whether it allows for fair and meaningful comparisons of performance on eligible professionals, and whether it is valid; and
- PQRI is not available to all specialties.

Response: Other than the information required by section 1848(m)(5)(G)(i) of the Act, the only PQRI information that we contemplated making public is the PQRI performance results for group practices selected to participate in the PQRI group practice reporting option (that is, group practices that have agreed to have their PQRI performance results publicly reported as a condition of utilizing the group practice reporting option). As stated above, we have taken commenters' concerns into consideration and have decided to defer implementation of public reporting of group practices' performance results until the 2011 PQRI program year.

Comment: One commenter requested clarification of the term ''satisfactorily submitted.'' The commenter recommended that we exercise flexibility until there is a guarantee that we can accurately collect and analyze the submission of quality data codes.

Response: We do not believe we have the authority to flexibly define the term ''satisfactorily submitted.'' Section 1848(m) of the Act clearly considers any eligible professional or group practice who satisfies the criteria for satisfactory reporting, as defined in sections II.G.2.e. through II.G.2.g. of this final rule with comment period, to be an eligible professional or group practice who qualifies for an incentive payment. Furthermore, section 1848(m)(5)(G) of the Act clearly requires us to post the names of eligible professionals or group practices that satisfactorily submitted data on PQRI quality measures.

After considering the comments above, we intend to post the names of eligible professionals who: (1) Submit data on the 2010 PQRI quality measures through one of the reporting mechanisms available for the 2010 PQRI; (2) meet one of the proposed satisfactory reporting criteria of individual measures or measures groups for the 2010 PQRI; and (3) qualify to earn a PQRI incentive payment for covered professional services furnished during the applicable 2010 PQRI reporting period for purposes of satisfying the requirements under section 1848(m)(5)(G)(i) of the Act, on the Physician and Other Health Care Professionals Directory.

Similarly, for purposes of satisfying the requirements under section 1848(m)(5)(G)(i) of the Act with respect to group practices, on the Physician and Other Health Care Professionals Directory, we intend to post the names of group practices that: (1) Submit data on the 2010 PQRI quality measures through the proposed group practice reporting option; (2) meet the proposed criteria for satisfactory reporting under the group practice reporting option; and (3) qualify to earn a PQRI incentive payment for covered professional services furnished during the applicable 2010 PQRI reporting period for group practices.

We do not intend to make performance rates for group practices participating in the 2010 PQRI group practice reporting option publicly available but anticipate publicly reporting group practices' performance results for the 2011 PQRI program year.

We anticipate that information with respect to quality data submitted for the 2010 PQRI (that is, the names of individual eligible professionals and group practices that satisfactorily report in 2010) will not be available until after the 2010 incentive payments are paid in 2011.

3. Section 131(c): Physician Resource Use Measurement and Reporting Program

a. Statutory Authority

As required under section 1848(n) of the Act, as added by section 131(c) of the MIPPA, we established and implemented by January 1, 2009, the Physician Resource Use Measurement & Reporting Program for purposes of providing confidential reports to physicians that measure the resources involved in furnishing care Medicare beneficiaries. Section 1848(n) of the Act also authorizes CMS to include information on the quality of care furnished to Medicare beneficiaries by a physician or group of physicians.

b. Background

As stated in the CY 2009 PFS final rule with comment period (73 FR 69866), the Program would consist of multiple phases. We included a summary of the activities of phase I of the Program in the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869). In addition to discussing phase I of the Program, we also highlighted the activities of several other initiatives, including Medicare Value-Based Purchasing (VBP) programs and demonstrations and related activities undertaken by the MedPAC and the Government Accountability Office (GAO). We refer readers to the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869) for a detailed discussion of these activities.

In the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869), we finalized, on an interim basis, the following parameters for phase I of the Program: (1) Use of both per capita and episode of care methodologies for resource use measurement; (2) cost of service category analysis (for example, imaging services or inpatient admissions); (3) use of 4 calendar years of claims data; (4) focus on high cost and/or high volume conditions; (5) reporting to physician specialties relevant to the selected focal conditions; (6) focus on physicians practicing in certain geographic areas, and (7) low, median, and high cost benchmarks.

In the CY 2010 PFS proposed rule (74 FR 33589 through 33591), we summarized the comments received from the CY 2009 PFS final rule with comment period and our responses. Further, we made the following proposals in the CY 2010 PFS proposed rule (74 FR 33591): (1) Reporting on quality measures in addition to resource use measures, and (2) reporting to groups of physicians in addition to individual physicians.

c. Phase I of the Program

As indicated above, the Program consists of multiple phases. Under this approach, each phase of the Program will inform future phases of the Program. We refer readers to the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869) for a description of phase I Program activities. Using the parameters that were finalized on an interim basis, we have disseminated approximately 310 resource use reports (a sample report is available at *http://rurinfo.mathematica-mpr.com/*) to physicians in 13 geographic regions (74 FR 33590). In the proposed rule, we solicited public comments on the interim final Program parameters.

Commenters supported the Program parameters that were finalized on an interim basis in the CY 2009 PFS final rule (73 FR 69866 through 69869). Our summary of those comments and our responses are contained in the CY 2010 PFS proposed rule (74 FR 33589 through 33591). Accordingly, we are finalizing the interim final Program parameters.

In addition to the eight conditions finalized on an interim basis in the CY 2009 PFS final rule(74 FR 33590), we solicited public comment on adding diabetes as an episode of care.

Comment: Commenters supported including diabetes as one of the selected episodes of care for the Program.

Response: We are finalizing adding diabetes to the episode of care analysis in the Program.

In the CY 2010 PFS proposed rule (74 FR 33591), we referred readers to the following Web site to review a de-identified sample of the resource use reports disseminated to physicians: *http://rurinfo.mathematica-mpr.com/.* We solicited public comment on the resource use report used in phase I of the Program.

Comment: Commenters supported dissemination of feedback reports both in hard copy and electronically.

Response: We intend to offer both hard copy and electronic delivery of feedback reports in the Program.

Comment: Commenters supported electronic reports that allow user-driven data drilldown capability to the claim level.

Response: We intend to explore the feasibility of such drill-down capability.

Comment: A few commenters suggested that additional cost of service categories (described on pages 30 and 34–35 at *http://rurinfo.mathematica-mpr.com/*) should be included in the feedback reports. Additional categories mentioned included: prescribed drugs, costs due to infections, and specific information on diagnostic tests and services.

Response: We intend to explore the feasibility of these additional cost of service categories in the future.

Comment: A few commenters suggested capturing hospital readmissions as a measure in the feedback reports.

Response: We are committed to closely monitoring hospital readmissions in the Medicare program. We intend to explore the feasibility of capturing readmissions in the physician group feedback reports in the future.

Comment: A few commenters stated that some of the benchmarks used in the reports were too broad in order to make meaningful peer comparisons.

Response: We are committed to refining the benchmarks used in the Program to ensure meaningful peer comparisons. We note that there is a trade-off between statistical precision and narrow benchmarks. For additional discussion on this statistical topic, we refer readers to the CY 2010 PFS proposed rule (74 FR 33590 through 33591). Further, we note that the broad geographic benchmarks provide additional value to CMS by informing policymakers of measurement variation across geographic regions.

Comment: A few commenters mentioned that eligible professionals would appreciate knowing each beneficiary that was assigned to them. Further, physicians would appreciate knowing which other physicians were also providing care to the beneficiaries assigned to them.

Response: To the extent it is practicable, we are committed to providing physicians with information that targets specific performance areas. We intend to explore the feasibility of providing this detailed level of data.

Comment: One commenter requested that CMS pursue a robust evaluation of the risk adjustment methodology (pages 29 and 32 at *http://rurinfo.mathematica-mpr.com/*) used in the Program.

Response: We are committed to conducting further research to refine the risk adjustment rules currently being applied in the Program. Determining how to accurately adjust for patient risk factors is a priority for CMS.

Comment: One commenter suggested that we make the minimum thresholds for patients and episodes that are needed for statistical accuracy used in the Program publicly available.

Response: We are committed to making the methodologies used in the Program transparent. We are currently exploring the feasibility of publicly posting the minimum thresholds for patients and episodes used in the Program on our Web site.

Comment: A few commenters suggested that additional outreach and education is needed to help eligible professionals understand the reports. Further, commenters suggested including a task in the next Quality Improvement Organization (QIO) scope of work to assist physicians with interpreting their reports.

Response: We are committed to providing technical assistance to eligible professionals to aide in the understanding of the reports. We intend to explore the feasibility of including a task to provide technical assistance in understanding the reports in the QIO 10th scope of work.

Comment: One commenter questioned how E/M codes included in surgical bundle payments are used to inform CMS' designated attribution methodologies.

Response: We are committed to pursuing further research in order to refine the designated attribution rules currently being applied in the Program. Determining how to accurately attribute surgical bundles is a priority for CMS.

Comment: One commenter requested that CMS raise the minimum of 10 percent of E/M costs used to assign a patient or episode to a physician.

Response: In addition to setting the minimum threshold at 10 percent, we will test some higher minimum thresholds. We note that one of the goals of this Program is to provide confidential feedback reports to as many physicians as possible. One of the trade-offs to raising the minimum threshold is that fewer physicians may qualify to receive a feedback report.

Comment: Several commenters strongly supported CMS' use of the multiple proportional attribution rule (pages 26–27 and 33 at *http://rurinfo.mathematica-mpr.com/*).

Response: We will continue to examine the utility of this attribution rule and test others.

In the CY 2010 PFS proposed rule, we referred readers to two publicly available Web sites for commercial episode grouper vendors regarding transparency of their methodologies (74 FR 33591). We solicited public comment on the use of proprietary products to measure episodes of care in the Program.

Comment: Many commenters were in favor of CMS only using a Medicare-specific public domain episode grouper in the Program.

Response: To the greatest extent practicable, we are committed to ensuring all methodologies used in the Program are transparent. We intend to explore the feasibility of using a Medicare-specific public domain episode grouper in the Program. We refer readers to (74 FR 48979 through 48980) for an announcement regarding an upcoming public listening session that CMS is hosting to discuss this topic.

d. Phase II of the Program

For phase II, we proposed to expand the Program in ways that that targets specific performance areas for physicians. We proposed to add reporting to groups of physicians, recognizing that many physicians practice in arrangements other than solo practices. We noted that group level reporting will be more likely to resolve the sample size issues that arise when individual physicians have too few Medicare beneficiaries with specific conditions to generate statistically significant information. We solicited public comment on potential types of groups including the following: (1) Formally-established single or multi-specialty group practices; (2) physicians practicing in defined geographic regions; and (3) physicians practicing

within facilities or larger systems of care.

Comment: Commenters supported reporting to groups of physicians, including all categories listed above, in addition to individual physicians. A few commenters questioned how CMS would define groups. Commenters did not offer a definition of group reporting, however. One commenter asked us to include accountable care organizations (ACOs) in the definition of the ''group.''

Response: We are finalizing our proposal to include group reporting. Since no explicit definition of group practice was suggested through public comment, for purposes of this Program, we are finalizing the following definition of group practice: more than one physician practicing medicine together. We choose this definition because we want to recognize groups of physicians as entities that are separate and distinct from individual physicians. We are defining a group as two or more physicians both to recognize groups as separate and distinct from individual physicians and to ensure that we have the broadest possible definition of a group so that all physicians could potentially be provided with resource use reports. If groups were to be defined more narrowly, it is possible that some physicians would not be subject to the resource use reporting because they are neither working in solo practice as an individual physician or part of a practice that meets our definition of a group.

This definition applies to the following groups: (1) Formally-established single or multi-specialty group practices; (2) physicians practicing in defined geographic regions; and (3) physicians practicing within facilities or larger systems of care. With respect to ACOs, the term is not defined at this time in either the law or regulations but to the extent that the ACO includes more than one physician, the physicians in the ACO would constitute a group for resource use reporting. We are therefore, finalizing the definition for group practices and these three types of groups of physicians.

Phase I of the Program focused on providing confidential feedback on resource use measures. Section 1848(n)(1)(A) of the Act states that the Secretary may also include information on the quality of care furnished to Medicare beneficiaries by physicians (or groups of physicians) in the feedback reports. Providing physicians with feedback on both quality and cost of care better captures the value of the care provided. Including quality measures in the Program is consistent with the direction for other CMS VBP initiatives. We solicited public comments on the use of PQRI, GEM, and other aggregate quality measures to be used in the Physician Resource Use Measurement and Reporting Program.

Comment: Commenters were unanimously supportive of including quality measures, in addition to resource use measures in the Program.

Response: We are finalizing our proposal to include quality measures in the Program.

Comment: Commenters were in support of using both PQRI and GEM measures to capture quality of care. Some commenters cited the new nature of both PQRI and GEM measures as an area of concern and recommended caution in using these quality measures until the measures become more mature.

Response: Though we recognize that both the measures used in the PQRI and claims-based measures calculated without submission of quality data codes from physicians (such as GEM measures) will continue to mature over time, we intend to include them in the Program. Including these quality measures will allow us to gain more experience reporting performance metrics to eligible professionals on a confidential basis.

Comment: In addition to the use of PQRI and GEM measures, commenters also encouraged reporting of structure and outcome measures (outside of those currently included in the PQRI Program). Commenters stated that specialty societies and other measure developers should be encouraged to speed the development of these types of measures.

Response: We are committed to capturing all aspects of performance, including process, structure, and outcomes measures. As additional measures become available, we will examine the utility of such measures as an additional aspect of reporting in this Program.

Comment: A few commenters expressed that quality data should closely relate to the episodes of care that are targeted in the Program.

Response: We are committed to working collaboratively with measure developers on pairing quality measures with episodes of care.

Comment: A few commenters recommended that the time period represented by the quality and cost measures should overlap.

Response: To the greatest extent practicable, we are committed to recognizing overlapping measurement time periods between quality and cost measures in this Program.

Comment: A few commenters suggested capturing quality data from registries.

Response: We are committed to allowing the collection of quality measures from data contained within clinical registries. We refer readers to section II.G.2. of this final rule with comment period that discusses the PQRI for additional discussion on the use of registries to collect quality data.

e. General Comments

In addition to the areas where we specifically solicited comments, we also received several general comments.

Comment: Some commenters expressed concern about the use of the data contained within the feedback reports for purposes beyond confidential reporting. One commenter strongly encouraged CMS to publicly report the data contained within the feedback reports.

Response: Section 1848(n) of the Act currently provides the authority to use the information contained within the feedback reports on a confidential basis only.

Comment: One commenter suggested integrating the reporting of resource use measures into Maintenance of Certification programs.

Response: CMS is committed to working collaboratively with stakeholders on various mechanisms and programs to increase the value of care delivered to beneficiaries. We refer readers to section II.G.2. of this final rule with comment period that discusses the PQRI for additional discussion of this suggestion.

Comment: One commenter suggested that the feedback reports be used to provide information on geographic variations in the delivery of specific services.

Response: We are committed to monitoring and addressing geographic variations in the delivery of services. As mentioned above, we plan to explore group level reporting, which may include reporting to physicians within a specified geographic group.

Comment: One commenter strongly encouraged CMS to expand the number of reports delivered beyond the 310 delivered in Phase I of the Program.

Response: We are committed to providing feedback to as many physicians as our resources will allow. We intend to explore the feasibility of providing more reports in the Program.

4. Section 131(d): Plan for Transition to Value-Based Purchasing Program for Physicians and Other Practitioners

a. Background

Value-based purchasing uses payment incentives and transparency to increase the value of care by rewarding providers for higher quality and more efficient services and for publicly reporting performance information. Section 131(d) of the MIPPA requires the Secretary to develop a plan to transition to a value-based purchasing (VBP) program for Medicare payment for covered professional services made under, or based on, the PFS. Section 131(d) of the MIPPA also states that by May 1, 2010, the Secretary shall submit a report to the Congress, containing the plan, together with recommendations for such legislation and administrative action as the Secretary determines appropriate. The Secretary, through the Physician and Other Health Professional VBP (PVBP) Workgroup, submitted a progress letter to Congress on January 8, 2009 detailing the progress made on the PVBP plan for physicians and other professionals.

Currently, Medicare health professional payments are based on quantity of services and procedures provided, without recognition of quality or efficiency. Under various authorities, we have pursued the implementation of building blocks to support the establishment of a VBP program for health professionals. These include initiatives in the following major topic areas: quality and efficiency measurement and reporting, approaches for aligning incentives with providing higher quality care instead of higher volume of care, care coordination, prevention, and health information technology (HIT). The following are examples of the initiatives specifically relevant to physicians and other health professionals:

- Pay for reporting of quality measurement data instituted under the Physician Quality Reporting Initiative (PQRI);
- Resource use reports comparing overall costs, as well as costs for treatment across episodes of care, as required by the Physician Resource Use Measurement and Reporting Program; and
- Demonstration projects including the Physician Group Practice demonstration of a shared savings model, gainsharing demonstrations, medical home and other care coordination and disease management demonstrations, and the Acute Care Episodes demonstration of a bundled payment model.

We are fully committed to implementing VBP incentives to drive quality improvement and greater efficiency for services furnished to Medicare beneficiaries.

b. Approach to Plan Development

We have created an internal cross-component team, the PVBP Steering Committee (formerly referred to as PVBP Workgroup), to lead development of the PVBP plan. Four Subgroups were established to address the major sections of the Plan: measures; incentives; data strategy and infrastructure; and public reporting. The PVBP Steering Committee was tasked with reviewing the state-of-the-art in performance-based payment for physicians, including relevant Medicare programs and demonstrations and private sector initiatives; preparing an Issues Paper to present program objectives and design principles; engaging stakeholders and obtaining input on program design; and developing the PVBP Plan and Report to Congress. A similar approach was used in the development of the CMS Hospital VBP Plan.

To guide the planning process, the PVBP Steering Committee adopted the following goal to improve Medicare beneficiary health outcomes and experience of care by using payment incentives and transparency to encourage higher quality, more efficient professional services. In pursuit of this goal, the Workgroup has defined the following objectives:

- Promote evidence-based medicine through measurement, payment incentives, and transparency.
- Reduce fragmentation and duplication through accountability across settings, alignment of measures and incentives across settings, better care coordination for smoother transitions, and attention to episodes of care.
- Encourage effective management of chronic disease by improving early detection and prevention, focusing on preventable hospital readmissions, and emphasizing the importance of advanced care planning and appropriate end-of-life care.
- Accelerate the adoption of effective, interoperable HIT, including clinical registries, e-prescribing, and electronic health records.
- Empower beneficiaries to make value-based health care choices, and encourage health professionals to improve the value of care they provide by disseminating information designed to help them change their practice patterns to improve performance.

The goal and objectives were captured in an Issues Paper that was posted on the CMS Web site on November 24, 2008, in preparation for the December 9, 2008 Listening Session which was held at CMS headquarters. The Issues Paper included questions seeking public input on key design considerations. The Issues Paper is available on the CMS Web site at *http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Paper.pdf*. Nearly 500 stakeholders participated in the day-long Listening Session. We received both verbal and written comments that are informing the design of the PVBP Plan. Stakeholder input from this Listening Session is summarized in the proposed rule (74 FR 33592 through 33593).

c. Next Steps in Plan Development

Building on input from the Listening Session on the Issues Paper topics, the PVBP Steering Committee has begun to develop potential recommendations for inclusion in the Report to Congress. The first step is to design various approaches for performance-based payment that will address the planning goal and objectives for different practice arrangements. This design process will include identifying appropriate measures and incentive structures, considering the necessary data infrastructure, and addressing public reporting options. Consideration will be given to approaches that:

(1) Overlay the current PFS, such as differential fee schedule payments based on measured performance;

(2) Address multiple levels of accountability, including individual health professionals, as well as larger care teams or organizations made up of a variety of health professionals and facilities; and

(3) Promote more integrated care through shared savings models and bundled payment arrangements.

In the proposed rule, we solicited public comment on the development of the PVBP plan and Report to Congress. We specifically requested for comments on two topics: (1) the appropriate level at which to hold practitioners accountable (for example, individuals or groups); and (2) appropriate data submission mechanisms. We received comments on these topics, as well as comments on other issues we should consider when developing the PVBP Report to Congress. The following is summary of the comments we received regarding section 131(d) of the MIPPA.

Comment: Regarding the appropriate level at which to hold practitioners accountable, commenters were supportive of our intention for the PVBP

plan to recognize multiple levels of accountability ranging from individual practitioners to larger organizations. Commenters recognized that a ''one size fits all'' approach would not be appropriate. One commenter suggested conducting a series of demonstrations and pilots to help further explore this issue. Commenters also urged us to design the program to allow participation by practitioners other than physicians.

Response: We plan to continue to explore ways to measure and incentivize practitioners for higher value care at multiple levels of accountability, including possible demonstrations and pilots to test and analyze the effectiveness of certain practice arrangements and payment systems. We recognize that the Congress intended the PVBP plan to be broader than physicians, and the PVBP Steering Committee is considering approaches that allow for participation by a wide variety of health care practitioners.

Comment: Regarding the appropriate methods for data submission, commenters overwhelmingly supported the adoption and use of interoperable electronic health records. Commenters suggested that the CMS PVBP Steering Committee coordinate with the Office of the National Coordinator for Health IT (ONC) to align PVBP incentives for electronic health records with the recently enacted HITECH incentives for health IT adoption. Commenters also recognized the role of registries in data submission. In addition, commenters urged us to carefully consider procedural protections for practitioners, such as allowing their review of their own data before submission to CMS.

Response: The CMS PVBP Steering Committee is exploring ways to encourage the use of interoperable health IT systems, including registries, as part of the PVBP plan. We have been actively engaged with ONC on how to align any PVBP incentives for health IT with the HITECH provisions and will continue to work closely with ONC. We recognize the importance of the accuracy and validity of electronically submitted data, and are exploring ways to incorporate data review processes for practitioners into the PVBP plan recommendations.

Comment: Several commenters were concerned with the relationship between the PVBP plan and the current Medicare payment system. Commenters stated that the current Medicare payment system is flawed in that it does not align incentives across providers and settings, and a PVBP plan that simply overlays the existing system will not be sufficient to re-align incentives to provide higher value care.

Response: In developing the PVBP plan, we are considering both short-term and long-term recommendations. Short-term recommendations may include changes within the current payment system. Such changes, though, would be interim steps toward implementing a more long-term approach for comprehensive payment reform.

Comment: Commenters urged us to not limit the Report to Congress to recommendations for only performance-based incentive payments. Commenters suggested the plan recommend a wide range of incentives for activities such as improving beneficiary health outcomes, patient experience of care, efficient performance of services, and use of electronic health IT such as registries or e-prescribing. Commenters also urged us to recommend using the PVBP plan to encourage high quality care by being actionable on the part of all practitioners.

Response: We are considering recommending a variety of different activities within the PVBP plan, taking into account what is more feasible in the short-term versus the long-term. We are also considering what program activities are likely to be the most meaningful and actionable for practitioners, both in the short-term and long-term.

Comment: Commenters urged CMS to gain experience with confidential feedback reporting of quality and resource use before using the information for either payment or public reporting. One commenter suggested that any public reporting under the PVBP plan should be geared toward consumer decision-making.

Response: We are considering a variety of program activities, including confidential feedback reports, public reporting, and incentive payments. The PVBP Steering Committee is carefully analyzing the options for each of these activities.

Comment: Several commenters mentioned that encouraging successful management of chronic disease is essential to any PVBP plan. Commenters mentioned medical home care models and the important role they can play in promoting integrated care and reducing costs.

Response: We recognize the importance of managing chronic disease, and are currently conducting a demonstration of the medical home concept. Findings from this demonstration may be used to inform plan development.

Comment: Commenters urged us to use the PVBP plan to increase efficiency and slow cost growth in the Medicare program. Commenters specifically mentioned shared savings models and encouraged us to further explore how to incorporate appropriate shared savings principles into the plan. There was no consensus among the comments regarding whether a PVBP plan should include shared savings or gainsharing. However, some commenters cautioned that a PVBP plan should not be viewed solely as a method to slow cost growth.

Response: We recognize the importance of both slowing cost growth and maintaining beneficiary access to high quality care. The PVBP plan will carefully explore program activities that accomplish both of these goals.

Comment: We received input on several issues related to the appropriate measurement of eligible professionals in a PVBP program. Commenters suggested we recommend only transparent evidence-based measures that are vetted by physician groups and endorsed by a national consensus-based organization. Commenters also suggested we recommend strategically selecting measures to address gaps in quality, or those related to high-cost and/or high-volume services. Measures used in the program should not be ''topped out,'' but still have significant room for improvement collectively across the Medicare program. In addition, commenters urged us to recommend the use of both quality and resource use information, and to report both domains of measures together in order to give a fuller picture of an eligible professional's performance. Commenters urged us to consider incorporating a broad range of quality measures into the PVBP program, including patient experience, clinical outcomes, disparities, care coordination, and structural measures such as the adoption of health IT.

Response: The PVBP Steering Committee is carefully considering what measures to recommend for which program activities (that is, incentive payment, confidential feedback, public reporting). We recognize the potential for the PVBP plan to address gaps in quality and high-cost and/or high volume services, and the importance of recommending the use of both quality and resource use information and the value to eligible professionals of providing this information together. We also recognize the importance of recommending the use of a broad array of measures. Many of the types of measures mentioned by commenters have not yet been fully developed. Therefore, short-term recommendations for the PVBP plan cannot include them, but long-term recommendations may encourage their development and use.

Comment: Commenters supported tying a portion of payment to an eligible professional's performance, and stated that participants should not be rewarded simply for reporting data to CMS. Commenters stated that the PVBP plan should reward both attainment of specified levels of performance, and improvement over time. Commenters also suggested that such incentive payments should be aimed toward breaking down the payment silos that currently exist between Medicare Parts A and B.

Response: Whether to reward eligible professionals for performance, and not merely participation is a key design option that the PVBP Steering Committee is considering for the PVBP plan. The Steering Committee will also carefully discuss whether to recommend paying incentives for attainment, improvement, or both.

Comment: Commenters stressed the importance of risk-adjustment, especially if performance data is used to make incentive payments.

Response: We recognize that risk-adjustment is essential and we are exploring methods for its incorporation into the PVBP plan.

Comment: Commenters commended CMS for involving stakeholders in PVBP plan development, and encouraged CMS to continue to involve stakeholders as plan development proceeds. Commenters urged CMS to ensure that any PVBP plan does not impede the evolution of medical practice, discourage innovation, or interfere with practitioner-patient decision-making.

Response: We appreciate the opportunity to hear from stakeholders regarding plan recommendations, and we value the input stakeholders have provided thus far. We are carefully considering options and taking an iterative approach to PVBP plan development to avoid the potential pitfalls mentioned by commenters.

We received other comments that were outside the scope of the proposed rule, and are therefore not discussed in this final rule with comment period.

5. Section 132: Incentives for Electronic Prescribing (E-Prescribing)—The E-Prescribing Incentive Program

a. Program Background and Statutory Authority

As described in the CY 2010 PFS proposed rule (74 FR 33593 through 33600), section 1848(m)(2) of the Act, as amended by section 132 of the MIPPA, promotes the use of electronic prescribing by authorizing incentive payments to eligible professionals or group practices who are ''successful electronic prescribers.'' This E-Prescribing Incentive Program is expected to encourage significant expansion of the use of electronic prescribing by authorizing a combination of financial incentives and payment adjustment and is separate from, and in addition to, any incentive payment that eligible professionals may earn through the PQRI program. Individual eligible professionals do not have to participate in PQRI in order to participate in the E-Prescribing Incentive Program (and vice versa).

For 2010, which is the second year of the E-Prescribing Incentive Program, the Secretary is authorized to provide successful electronic prescribers, as defined in section 1848(m)(3)(B) of the Act and further discussed below in this section, an incentive payment equal to 2.0 percent of the total estimated Medicare Part B PFS allowed charges (based on claims submitted not later than 2 months after the end of the reporting period) for all covered professional services furnished during the 2010 reporting period. Covered professional services are defined under the statute to be services for which payment is made under, or is based on, the PFS and which are furnished by an eligible professional. The applicable electronic prescribing percent (2.0 percent) authorized for the 2010 E-Prescribing Incentive Program is the same as that authorized for the 2009 E-Prescribing Incentive Program.

We received several comments from the public on the CY 2010 PFS proposed rule related to the E-Prescribing Incentive Program. General comments about the E-Prescribing Incentive Program are addressed immediately below.

Comment: One commenter was opposed to making any changes to the E-Prescribing Incentive Program for 2010, but a majority of the comments voiced their support for the changes proposed for the 2010 E-Prescribing Incentive Program and discussed below.

Response: Although we understand the commenter's desire to keep the program the same in 2010, we believe that this would defeat our attempts to simplify the E-Prescribing Incentive Program and reduce the reporting burden for eligible professionals.

Comment: Some comments recommended that we conduct significant education and outreach activities, especially with respect to the changes for 2010, and that we promote the program by making participation information, as well as information about potential incentive payment amounts available.

Response: We value the input received from stakeholders and participants who have provided constructive feedback and have collaborated with us to disseminate educational materials about the E-Prescribing Incentive Program to eligible professionals in the health care community. We anticipate that ongoing education and outreach efforts will continue to evolve with the program. We will continue to work with national and regional stakeholder organizations to educate their members on program requirements for successful reporting, especially the changes that will be implemented for 2010, as discussed below. We also plan to continue to host monthly national provider calls in which we expect to provide guidance on specific topics, including having our E-Prescribing Incentive Program subject matter experts available to answer questions. Information about upcoming calls can be obtained from the CMS Sponsored Calls page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/04_CMSSponsoredCalls.asp#TopOfPage.* We will also continue to make educational materials and other resources available on the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/erxincentive*. We encourage eligible professionals to visit this Web site and to review the frequently asked questions found on this Web site. Eligible professionals are also encouraged to join our physician listserv to obtain periodic updates about the E-Prescribing Incentive Program. Instructions for joining the listserv can be found at *https://list.nih.gov/archives/physicians-l.html.*

Comment: One commenter recommended that we promote the program by making participation information, as well as information about potential incentive payment amounts available.

Response: Once the 2009 program year is complete, we anticipate conducting an evaluation of the 2009 E-Prescribing Incentive Program reporting experience at an aggregate level and posting a national summary report similar to the ''PQRI 2007 Reporting Experience'' report found at *http://www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportFinal12032008CSG.pdf.*

With respect to the suggestion to make information about potential incentive payment amounts available, we are concerned that doing so may be misleading since incentive payments will differ for each eligible professional based on his or her Medicare Part B PFS allowed charges for covered

professional services. We believe that information such as the mean incentive payment amount released in the ''PQRI 2007 Reporting Experience'' report could serve the same purpose.

Comment: Many commenters expressed a desire for the Drug Enforcement Agency (DEA) to permit electronic prescribing of controlled substances. Commenters noted that until electronic prescribing of controlled substances is permitted, eligible professionals may be reluctant to adopt electronic prescribing technology due to work flow issues and the need to utilize two processes (electronic and written) for generating prescriptions.

Response: We are aware of the current limitation for electronic prescribing of controlled substances. Actions taken or that may be taken by the DEA are beyond our purview. However, we have taken this limitation into consideration in establishing the 2010 criteria for determining a successful electronic prescriber.

Comment: Some commenters suggested that we obtain data on electronic prescribing from pharmacies rather than eligible professionals or that we should also be holding pharmacies or pharmacy networks accountable for ensuring accurate, timely, and consistent transmission of electronic prescribing data.

Response: As established by MIPPA, the E-Prescribing Incentive Program is an incentive program specifically for eligible professionals, as defined by section 1848(k)(3)(B) of the Act, based on information submitted by eligible professionals. Additionally, section 1848(m)(3)(B)(iv) of the Act authorizes the use of Part D data, which reflects information submitted by pharmacies to Part D plan sponsors. As we explained in the CY 2010 PFS proposed rule (74 FR 33595), however, the accuracy and completeness of the Part D data with respect to whether a prescription was submitted electronically is unknown since Part D plan sponsors will not be required to start submitting this information until 2010. Should we rely on Part D data in the future, we anticipate that we will no longer need eligible professionals to submit data on their electronic prescribing activities to us.

Comment: One commenter was concerned that the E-Prescribing Incentive Program will include a penalty, or payment adjustment, to begin in 2012 and requested that we, in consultation with stakeholders, define in a timely manner how we intend to use the case-by-case, significant hardship penalty exemption authority.

Response: We believe the commenter is referring to section 1848(a)(5)(B) of the Act, which permits the Secretary, on a case-by-case basis, to exempt an eligible professional from the application of the payment differential if the Secretary ''determines, subject to annual renewal that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship.'' This hardship exemption is to be used at the discretion of the Secretary.

As we stated in the CY 2009 PFS proposed rule (74 FR 33549), we will discuss the application of the payment adjustment in future notice and comment rulemaking. We will address the circumstances under which the hardship exemption applies at that time.

Comment: One commenter recommended that we provide a participation option for eligible professionals who predominately practice in skilled nursing facilities. The commenter is concerned that many such professionals are currently unable to participate in the E-Prescribing Incentive Program because the facility's prescribing systems generate orders to an internal pharmacy and, for reasons unspecified by the commenter, do not meet the full definition of a qualified electronic prescribing system.

Response: Since the commenter did not describe what aspects of the definition of ''qualified'' electronic prescribing system a skilled nursing facility's electronic prescribing system fails to meet, it is not entirely clear how the fact that a facility's electronic prescribing system generates orders to an internal pharmacy alone would prevent the facility's system from meeting the definition of a ''qualified'' electronic prescribing system. In an attempt to provide eligible professionals who predominately practice in skilled nursing facilities with more opportunities to participate in the E-Prescribing Incentive Program, however, we are expanding the scope of the electronic prescribing measure's denominator codes to include professional services outside the professional office and outpatient setting. The expanded codes include professional services furnished in skilled nursing facilities and in the home care setting. To be considered a successful electronic prescriber, eligible professionals need only to report 25 separate electronic prescribing events during the reporting period. To qualify for the electronic prescribing incentive payment, a successful electronic prescriber must have 10 percent of their Medicare Part B PFS allowed charges for covered professional services be comprised of the codes in the denominator of the measure. The electronic prescribing system used for these 25 electronic prescribing events must have all of the functionalities listed in the measure's specifications and described in section II.G.5.c.3. below.

Comment: One commenter was concerned that the incentive payment favors prescribers who typically bill high-cost services since the incentive payment is based on Medicare Part B PFS allowed charges. The commenter suggested that the incentive payment should be a flat-rate bonus or a bonus payment that rewards medication management.

Response: We appreciate the comment; however, we do not have the authority to change the basis for the calculation of the incentive payment amount, which is defined in section 1848(m)(2)(A) of the Act.

b. The 2010 Reporting Period for the E-Prescribing Incentive Program

Section 1848(m)(6)(C)(i)(II) of the Act defines ''reporting period'' for the 2010 E-Prescribing Incentive Program to be the entire year. Section 1848(m)(6)(C)(ii) of the Act, however, authorizes the Secretary to revise the reporting period for years after 2009 if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. In the CY 2010 PFS proposed rule (74 FR 33594 through 33595), we proposed that the 2010 E-Prescribing Incentive Program reporting period would be the entire calendar year (January 1, 2010–December 31, 2010).

Comment: A majority of commenters supported the proposed reporting period. One commenter, however, recommended two 6-month reporting periods, because this would allow eligible professionals who are able to implement electronic prescribing in their practice by the middle of 2010 to still benefit from the incentive for 2010.

Response: We do not believe that adoption and implementation of an electronic prescribing system after the start of the 2010 reporting period would necessarily preclude an individual eligible professional from being able to qualify for the incentive payment. The 25 electronic prescribing events required to meet the criteria for successful electronic prescriber for 2010 (see section II.G.5.c. below) can be reported at any time during the 2010 reporting period.

After considering these comments, we are finalizing the entire calendar year as

the 2010 reporting period for the E-Prescribing Incentive Program. Successful electronic prescribers will be eligible to receive an incentive payment equal to 2.0 percent of the total estimated Medicare Part B PFS allowed charges (based on claims submitted by no later than February 28, 2011) for all covered professional services furnished January 1, 2010 through December 31, 2010.

c. Criteria for Determination of Successful Electronic Prescriber for Eligible Professionals

Under section 1848(m)(3)(B) of the Act, in order to qualify for the incentive payment, an eligible professional must be a ''successful electronic prescriber,'' which the Secretary is authorized to identify using 1 of 2 possible criteria. One criterion, under section 1848(m)(3)(B)(ii) of the Act, is based on the eligible professional's reporting, in at least 50 percent of the reportable cases, on any electronic prescribing quality measures that have been established under the physician reporting system, under subsection 1848(k) of the Act (which, as noted previously, we have named ''PQRI'' for ease of reference) and are applicable to services furnished by the eligible professional during a reporting period. We applied this criterion in 2009. However, for years after 2009, section 1848(m)(3)(D) of the Act permits the Secretary in consultation with stakeholders and experts to revise the criteria for submitting data on electronic prescribing measures under section 1848(3)(B)(ii) of the Act.

The second criterion, under section 1848(m)(3)(B)(iii) of the Act, is based on the electronic submission by the eligible professional of a sufficient number (as determined by the Secretary) of prescriptions under Part D during the reporting period. If the Secretary decides to use the latter standard, then, in accordance with section 1848(m)(3)(B)(iv) of the Act, the Secretary is authorized to use Part D drug claims data to assess whether a ''sufficient'' number of prescriptions have been submitted by eligible professionals. However, under section 1848(m)(3)(B)(i) of the Act, if the standard based on a sufficient number (as determined by the Secretary) of electronic Part D prescriptions is applied for a particular reporting period, then the standard based on the reporting on electronic prescribing measures would no longer apply.

For 2010, we proposed to continue to require eligible professionals to report on the electronic prescribing measure used in the 2009 E-Prescribing Incentive Program to determine whether an eligible professional is a successful electronic prescriber, but we proposed to modify the measure's specifications and to use modified reporting criteria based on the authority provided under section 1848(m)(3)(D) of Act, as discussed below.

(1) Reporting the Electronic Prescribing Measure

For 2010, we proposed to make 3 reporting mechanisms available to individual eligible professionals to report the electronic prescribing measure. First, we proposed to retain the claims-based reporting mechanism that is used in the 2009 E-Prescribing Incentive Program. In addition, similar to the PQRI, for the E-Prescribing Incentive Program, we proposed to implement a registry-based reporting mechanism and, depending on whether we finalize the proposed EHR-based reporting mechanism for PQRI, we also proposed that an EHR-based reporting mechanism be available for the electronic prescribing measure.

We proposed that only registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2010 PQRI would be qualified to submit measure results and numerator and denominator data on the electronic prescribing measure on behalf of eligible professionals for the 2010 E-Prescribing Incentive Program. Similarly, we proposed that only EHR products ''qualified'' to potentially be able to submit clinical quality data extracted from the EHR to CMS for the 2010 PQRI would be considered ''qualified'' for the purpose of an eligible professional potentially being able to submit data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program.

We solicited comments on our proposal to provide alternatives to the claims-based reporting mechanism for reporting the electronic prescribing measure, as well as on our proposal to limit the registries and EHR products qualified to submit the electronic prescribing measure for the 2010 E-Prescribing Incentive Program to those that are qualified registries and EHR products, respectively, for the 2010 PQRI.

All commenters supported having alternatives to the claims-based reporting mechanism for reporting the electronic prescribing measure. All commenters were also in agreement that only registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2010 PQRI and EHR products ''qualified'' to submit clinical quality data extracted from the EHR to CMS for the 2010 PQRI be considered ''qualified'' for the purpose of an eligible professional being able to submit data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program. Based on these comments, we are finalizing our proposal that for the 2010 E-Prescribing Incentive Program, eligible professionals will be able to choose whether to submit data on the electronic prescribing measure through claims, a qualified registry, or a qualified EHR product.

Only registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2010 PQRI will be qualified to submit measure results and numerator and denominator data on the electronic prescribing measure on behalf of eligible professionals for the 2010 E-Prescribing Incentive Program. We will post a list of qualified registries for the 2010 E-Prescribing Incentive Program on the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive* when we post the list of qualified registries for the 2010 PQRI on the PQRI section of the CMS Web site (see section II.G.2. of this final rule with comment period). Not all registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2010 PQRI will be qualified to submit quality measure results and numerator and denominator data on the electronic prescribing measure. That is to say that PQRI qualified registries may not wish to be qualified to submit all measures. The electronic prescribing measure is reportable by an eligible professional any time he or she bills for one of the procedure codes for Part B covered professional services included in the measure's denominator. Some registries that self-nominate to become a qualified registry for PQRI may not choose to self-nominate to become a qualified registry for submitting measures that require reporting at each eligible visit, such as the electronic prescribing measure. Therefore, we cannot guarantee that there will be a registry willing to submit the electronic prescribing measure on behalf of eligible professionals. Registries will need to indicate their desire to qualify to submit measure results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing

Incentive Program at the time that they submit their self-nomination letter for the 2010 PQRI.

Similarly, only EHR products ''qualified'' to submit clinical quality data extracted from the EHR to CMS for the 2010 PQRI will be considered ''qualified'' for the purpose of an eligible professional being able to submit data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program. As stated in section II.G.2.d.3. of this final rule with comment period, 2009 EHR Testing Program is underway. Therefore, we cannot guarantee that any of the EHR vendors that self-nominated to have one or more of their EHR products ''qualified'' for the PQRI will successfully complete the testing process and therefore, be eligible for participation as a qualified EHR vendor the E-Prescribing Incentive Program. An EHR vendor will need to indicate its intention to have one or more of their EHR products qualified for the purpose of an eligible professional potentially being able to submit data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program at the time that they are being vetted for the 2010 PQRI. We will post a list of qualified EHR vendors and products for the 2010 E-Prescribing Incentive Program on the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive* when we post the list of qualified EHR vendors and products for the 2010 PQRI on the PQRI section of the CMS Web site (see section II.G.2. of this final rule with comment period). We anticipate completing the 2009 PQRI EHR Testing Program in early 2010.

(2) The Reporting Denominator for the Electronic Prescribing Measure

The electronic prescribing measure, similar to the PQRI measures, has 2 basic elements, which include: (1) a reporting denominator that defines the circumstances when the measure is reportable; and (2) a reporting numerator.

The denominator for the electronic prescribing measure consists of specific billing codes for covered professional services. The measure becomes reportable when any one of these procedure codes is billed by an eligible professional for Part B covered professional services. As initially required under section 1848(k)(2)(A)(ii) of the Act, and further established through rulemaking and under section 1848(m)(2)(B) of the Act, we may modify the codes making up the denominator of the electronic prescribing measure. As such, we proposed to expand the scope of the denominator codes for 2010 to covered professional services outside the professional office and outpatient setting, such as professional services furnished in skilled nursing facilities or the home care setting. We proposed to add the following CPT codes to the denominator of the electronic prescribing measure for 2010: 90862, 99304; 99305; 99306; 99307; 99308; 99309; 99310; 99315; 99316; 99341; 99342; 99343; 99344; 99345; 99347; 99348; 99349; and 99350. We solicited comments on the proposed changes to codes identified for the electronic prescribing measure denominator.

The following is a summary of the comments we received regarding the proposed denominator codes for the 2010 electronic prescribing measure.

Comment: Many commenters supported the proposed expansion of the electronic prescribing measure's denominator codes. However, some commenters noted that a subset of home care physicians will not be able to participate in the E-Prescribing Incentive Program without the addition of codes for domiciliary care visits in the measure's denominator.

Response: We appreciate the commenters' support of the proposed denominator codes. Based on comments indicating that some eligible professionals exclusively make domiciliary care visits, we are adding the following codes to the electronic prescribing measure's denominator for 2010: 99324 through 99328; 99334 through 99337; and 99346.

Comment: Other commenters suggested additional codes for inclusion in the measure's denominator, including an annual nursing facility assessment code (CPT code 99318) in lieu of CPT codes 99307 through 99310, inpatient evaluation and management (E/M) codes, codes for professional services furnished in renal dialysis facilities (CPT codes 90951 through 90970 for outpatient dialysis), and interactive psychotherapy codes (CPT codes 90810 through 90815).

Response: With respect to commenters' suggestions to add other denominator codes that were not proposed, we do not believe it is necessary to expand the denominator codes to include the suggested codes. As we stated previously, the electronic prescribing measure becomes reportable when any one of the procedure codes included in the measure's denominator is billed by an eligible professional for Part B covered professional services. Eligible professionals only need to have 10 percent of their Medicare Part B PFS allowed charges for covered professional services be comprised of the codes in the denominator of the measure and meet the criteria for determining a successful electronic prescriber to qualify to earn an electronic prescribing incentive payment. The incentive payment amount, however, will be calculated based on all of the eligible professional's total estimated Medicare Part B PFS allowed charges for covered professional services, including the services reflected in the suggested codes if such services are Medicare Part B PFS covered professional services.

Accordingly, we are finalizing the following denominator codes for the 2010 electronic prescribing measure: 90862; 99304; 99305; 99306; 99307; 99308; 99309; 99310; 99315; 99316; 99324; 99325; 99326; 99327; 99328; 99334; 99335; 99336; 99337; 99341; 99342; 99343; 99344; 99345; 99346; 99347; 99348; 99349; and 99350. There are no diagnosis codes in the measure's denominator and there are no age/gender requirements in order for a patient to be included in the measure's denominator (that is, reporting of the electronic prescribing measure is not further limited to certain ages or a specific gender). Eligible professionals are not required to report this measure in all cases in which the measure is reportable. Eligible professionals who do not bill for one of the procedure codes for Part B covered professional services included in the measure's denominator will have no occasion to report the electronic prescribing measure.

By December 31, 2009, we will post the final specifications of the measure on the ''E-Prescribing Measure'' page of the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive.*

(3) Qualified Electronic Prescribing System—Required Functionalities and Part D E-Prescribing Standards

To report the electronic prescribing measure in 2010, we proposed that the eligible professional must report one of the measure's numerator ''G'' codes (74 FR 33597). However, when reporting any of the G-codes for purposes of qualifying for the incentive payment for electronic prescribing in 2010, we proposed that the professional must have and regularly use a ''qualified'' electronic prescribing system, as defined in the electronic prescribing measure specifications.

Required Functionalities for a ''Qualified'' Electronic Prescriber System. We proposed (74 FR 33596 through 33597) that what constitutes a ''qualified'' electronic prescribing

system is based upon certain required functionalities that the system can perform (74 FR 33596 through 33597). As currently specified in the electronic prescribing measure for 2009, a ''qualified'' electronic prescribing system would be one that can:

(a) Generate a complete active medication list incorporating electronic data received from applicable pharmacies and PBMs, if available.

(b) Allow eligible professionals to select medications, print prescriptions, electronically transmit prescriptions, and conduct alerts (written or acoustic signals to warn the prescriber of possible undesirable or unsafe situations including potentially inappropriate dose or route of administration of a drug, drug-drug interactions, allergy concerns, or warnings and cautions). This functionality must be enabled.

(c) Provide information related to lower cost, therapeutically appropriate alternatives (if any). The ability of an electronic prescribing system to receive tiered formulary information, if available, would suffice for this requirement for 2010 and until this function is more widely available in the marketplace.

(d) Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available).

Part D Electronic Prescribing Standards. Section 1848(m)(3)(B)(v) of the Act specifies that to the extent practicable, in determining whether an eligible professional is a successful electronic prescriber, ''the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1860D–4(e)'' of the Act. The Part D standards for electronic prescribing systems establish which electronic standards Part D sponsors, providers, and dispensers must use when they electronically transmit prescriptions and certain prescription related information for Part D covered drugs that are prescribed for Part D eligible individuals. To be a qualified electronic prescribing system under the current E-Prescribing Incentive Program, electronic systems must convey the information listed above under (a) through (d) using the standards currently in effect for the Part D electronic prescribing program. Additional Part D electronic prescribing standards were implemented April 1, 2009. These latest Part D electronic prescribing standards, and those that had previously been adopted, can be found on the CMS Web site at *http://www.cms.hhs.gov/eprescribing.*

To ensure that eligible professionals utilize electronic prescribing systems that meet these requirements, the electronic prescribing measure requires that those functionalities required for a ''qualified'' electronic prescribing system utilize the adopted Part D electronic prescribing standards. The Part D electronic prescribing standards relevant to the four functionalities for a ''qualified'' system in the electronic prescribing measure, described above and listed as (a), (b), (c), and (d), currently are:

(a) Generate medication list—Use the National Council for Prescription Drug Programs (NCPDP) Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide, Version 8, Release 1, October 2005 (hereinafter ''NCPDP SCRIPT 8.1'') Medication History Standard;

(b) Transmit prescriptions electronically—Use the NCPDP SCRIPT 8.1 for the transactions listed at § 423.160(b)(2);

(c) Provide information on lower cost alternatives—Use the NCPDP Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0 (Version 1.0), October 2005 (hereinafter ''NCPDP Formulary and Benefits 1.0'');

(d) Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan—use:

(1) NCPDP Formulary and Benefits 1.0 for communicating formulary and benefits information between prescribers and plans;

(2) Accredited Standards Committee (ASC) X12N 270/271—Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000, Washington Publishing Company, 004010X092 and Addenda to Health Care Eligibility Benefit Inquiry and Response, Version 4010A1, October 2002, Washington Publishing Company, 004010X092A1 for communicating eligibility information between the plan and prescribers;

(3) NCPDP Telecommunication Standard Specification, Version 5, Release 1 (Version 5.1), September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000 for communicating eligibility information between the plan and dispensers.

There are, however, Part D electronic prescribing standards that are in effect for functionalities that are not commonly utilized at this time. Such functionalities are not currently required for a ''qualified'' system under the E-Prescribing Incentive Program. One example is Rx Fill Notification, which is discussed in the Part D electronic prescribing final rule (73 FR 18918, 18926). For purposes of the 2010 Electronic Prescribing Program and incentive payments, we did not propose to require that an electronic prescribing system contain all functionalities for which there are available Part D electronic prescribing standards. For those required functionalities described above, we proposed that a ''qualified'' system must use the adopted Part D electronic prescribing standards for electronic messaging.

The following is a summary of the comments we received regarding the proposed required functionalities and Part D electronic prescribing standards for a qualified electronic prescribing system for 2010.

Comment: Many commenters supported the list of required functionalities for what constitutes a ''qualified'' system.

Response: We appreciate the commenters' positive feedback. We believe the list of required functionalities leverage many of the potential advantages to electronic prescribing, such as, but not limited to, improving patient safety and quality of care, improving formulary adherence, and providing access to patient's medication history.

Comment: One commenter requested clarification with respect to qualification (b) above, which requires that the functionality to allow eligible professionals to select medications, print prescriptions, electronically transmit prescriptions, and conduct alerts be enabled. The commenter recommended that we clarify in the final rule that '' 'printing prescriptions' from a qualified electronic prescribing system does *not* meet the criteria for 'creating' or 'generating' an e-prescription.''

Response: All functionalities required of a ''qualified'' electronic prescribing system must be enabled. As noted by the commenter, printed prescriptions, however, do not qualify as an electronic prescribing event. In order for a prescription to be considered an electronic prescribing event, the prescription must be transmitted electronically using the applicable standards and the prescriber's system must warn the prescriber of possible undesirable or unsafe situations.

Comment: One commenter recommended that we clearly articulate how we will align the definition of being a ''successful electronic

prescriber'' with the forthcoming ''meaningful use'' definition related to health information technology. Particularly, commenter recommended that the standards should come together in 2011 to promote the objective that for BOTH sets of incentives clinicians:

- Use computerized physician order entry (CPOE) for all orders;
- Implement drug/drug, drug/allergy, drug/formulary checks;
- Generate and transmit permissible prescriptions electronically;
- Maintain active medication lists; and
- Maintain active medication allergy lists.

The commenter is concerned that in the absence of greater alignment, the electronic prescribing standard will be inconsistent with the proposed meaningful use definition, and could undermine that definition and confuse clinicians.

Response: CMS is actively working internally and with external agencies, such as the Office of the National Coordinator (ONC) on meaningful use and its implications relative to our PQRI and E-prescribing Incentive Programs. Guidance on the definition of ''meaningful use'' is beyond the scope of this rule and will be provided in separate notice and comment rulemaking specifically addressing meaningful use.

Comment: One commenter recommended that CMS provide a list of qualified systems in order to assist eligible professionals with accurately selecting a system.

Response: We are unable to provide this information since we do not vet electronic prescribing systems to ensure that the systems have all of the required functionalities. Eligible professionals should be able to assess whether a system is qualified by going through the list of required functionalities and asking the system's vendor whether the system is capable of doing all of the required functionalities.

After considering the comments, we are finalizing as the required functionalities for a qualified electronic prescribing system for 2010 those outlined in the section above entitled ''Required Functionalities for a 'Qualified' Electronic Prescribing System.'' In addition, for each required functionality of a qualified system, the system must use the adopted Part D electronic prescribing standards for electronic messaging listed above in the section entitled ''Part D Electronic Prescribing Standards.''

There are other aspects of the functionalities for a ''qualified'' system that are not dependent on electronic messaging and are part of the software of the electronic prescribing system, for which Part D standards for electronic prescribing do not pertain and are not required for purposes of the E-Prescribing Incentive Program. For example, the requirements in qualification (b) listed above that require the system to allow professionals to select medications, print prescriptions, and conduct alerts are functions included in the particular software, for which Part D standards for electronic messaging do not apply.

We are aware that there are significant numbers of eligible professionals who are interested in earning the incentive payment, but currently do not have an electronic prescribing system. The electronic prescribing measure does not require the use of any particular system or transmission network; only that the system be a ''qualified'' system having the functionalities described above based on Part D electronic prescribing standards. If the professional does not have general access to an electronic prescribing system in the practice setting, there is nothing to report and the eligible professional would not be able to participate in the E-Prescribing Incentive Program.

(4) The Reporting Numerator for the Electronic Prescribing Measure

Currently, to report for an applicable case where 1 of the denominator codes is billed for Part B covered professional services, an eligible professional must report 1 of 3 G-codes specified in the electronic prescribing measure.

For 2010, we proposed to modify the first G-code (G8443) to indicate that at least 1 prescription in connection with the visit billed was electronically prescribed (74 FR 33597). In addition, we proposed to eliminate the 2 remaining G-codes from the measure's numerator: G8445: Qualified E-prescribing System Available, but no Prescription(s) were Generated During the Encounter; and G8446: E-prescribing System Available, but not Used for One or More Prescriptions Due to Patient/System Reasons. We solicited comments on the proposed modifications to the electronic prescribing measure numerator.

The following is a summary of the comments we received regarding the proposed reporting numerator for the electronic prescribing measure for 2010.

Comment: A majority of commenters supported simplification of the measure's numerator to only 1 G-code. However, one commenter was opposed to the elimination of both the G8445 and G8446 codes, while other commenters were specifically opposed to the elimination of the G8446 code. The commenters believed that continued reporting is needed for cases in which an eligible professional would have electronically prescribed had electronic prescribing been possible, such as electronic prescribing of controlled substances.

Response: We are finalizing our proposal to modify the G-codes for the electronic prescribing measure. Since we are revising the criteria for determining that an eligible professional is a successful electronic prescriber to assess the actual number of electronic prescribing events (with the minimum threshold of 25 events) during the reporting period rather than assessing the percentage of eligible cases on which an eligible professional reported the measure, we believe it is no longer necessary to require eligible professionals to report the measure to us for cases where an eligible professional would have electronically prescribed but electronic prescribing was not possible or that no prescriptions were generated.

Comment: One commenter requested clarification on whether the revised G8443 code indicates at least one prescription ''generated'' by a qualified system or indicates at least one prescription ''sent electronically.''

Response: The new G-code for 2010 indicates that at least 1 prescription created during the encounter was generated and transmitted electronically using a qualified electronic prescribing system.

Comment: Another commenter suggested that instead of modifying the G-code to indicate that at least 1 prescription in connection with the visit billed was electronically prescribed, we should modify the G-code to indicate that ''at least 1 electronic prescription submitted for all qualified prescriptions for this visit.'' This would allow eligible professionals to report the G-code in all of the following circumstances: (1) All prescriptions were transmitted electronically; (2) some prescriptions were transmitted electronically; other prescriptions did not qualify for electronic transmittal; and (3) no prescriptions were submitted or qualified for electronic transmittal. The commenter was concerned that the proposed single G-code approach would not allow measure rates to be calculated as the numerator would not include visits for which no qualified prescriptions were submitted. The commenter further recommended that the measure rate calculations exclude instances where there were qualified

prescriptions, but no prescriptions were transmitted electronically.

Response: We appreciate the commenter's feedback. However, before eligible professionals can begin using electronic prescribing technology, they must first adopt the technology. Since, as we discussed in the CY 2010 PFS proposed rule (74 FR 33593), rates for the adoption and use of electronic prescribing technology by eligible professionals are still low and 2010 is only the second year of this incentive program, our goal for the 2010 E-Prescribing Incentive Program is to focus on increasing eligible professionals' adoption of electronic prescribing technology. We believe that this will be facilitated by administering the E-Prescribing Incentive Program in a way that does not create an unnecessarily large reporting burden on eligible professionals in order to qualify for the incentive.

The criteria for successful reporting we are finalizing for 2010 are designed to reward those eligible professionals who demonstrate that they have adopted a qualified electronic prescribing system and actually used the system in a substantial way to electronically prescribe. In this context, the reporting of information as to circumstances where a professional did not electronically prescribe is not pertinent. Additionally, although it may be of interest to measure the proportion of prescribing events that are electronic, we do not believe such detail at the individual or group practice level is of sufficient value to warrant the high burden of reporting such information. We do note that in the future the use of Part D claims data may allow this information to be collected without the necessity for professionals to specifically report such details.

Accordingly, for the 2010 electronic prescribing measure, we are finalizing the following numerator G-code: Gxxxx: At least 1 prescription created during the encounter was generated and transmitted electronically using a qualified electronic prescribing system.

A new G-code will be assigned by CMS to the above code for 2010 and will be included in the measure's specifications, which we will post on the ''E-Prescribing Measure'' page of the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive.* We will post by no later than December 31, 2009, the final electronic prescribing measure specifications for 2010.

Because the electronic prescribing quality measure will apply only when an eligible professional furnishes services indicated by one of the codes included in the measure's denominator, for claims-based reporting, for example, it will not be necessary for an eligible professional to report G-codes for the electronic prescribing measure on claims not containing one of the denominator codes. However, if reporting a G-code, the G-code data submission will only be considered valid if it appears on the same Medicare Part B claim containing one of the electronic prescribing quality measure's denominator codes.

In addition, if the eligible professional submits a Medicare Part B claim containing one of the electronic prescribing measure's denominator codes, he or she can report the numerator G-code only when the eligible professional furnishes services indicated by one of the G-codes included in the measure's numerator. That is, only when at least 1 prescription created during the encounter was generated and transmitted electronically using a qualified electronic prescribing system.

(5) Criteria for Successful Reporting of the Electronic Prescribing Measure

As discussed above, section 1848(m)(3)(B)(ii) of the Act specifies that an eligible professional shall be treated as a successful electronic prescriber for a reporting period based on the eligible professional's reporting of the electronic prescribing measure in at least 50 percent of applicable cases. For 2010, however, we proposed to exercise our authority under section 1848(m)(3)(D) of the Act to revise the criteria for submitting data on the electronic prescribing measure (74 FR 33598). For 2010, rather than requiring that the electronic prescribing measure be reported for a certain proportion of reportable cases, we proposed to make the determination of whether an eligible professional is a successful electronic prescriber based on a count of the number of times (minimum threshold of 25) an eligible professional reports that at least one prescription created during the encounter was generated using a qualified electronic prescribing system. We solicited comments on the proposed criteria for determination of successful electronic prescriber.

The following is a summary of the comments we received regarding the proposed criteria for determination of successful electronic prescriber for the 2010 E-Prescribing Incentive Program.

Comment: A majority of commenters supported the changes proposed for the criteria for the determination of successful electronic prescriber for 2010 and the proposed threshold for reporting the electronic prescribing measure at least 25 times during the reporting period. Some commenters, however, expressed concern that the proposed threshold may be insufficient to ensure that electronic prescribing is fully adopted into the prescriber's clinical practice and workflow since some eligible professionals may be able to meet this threshold in a matter of a few days or weeks.

Some commenters suggested that in lieu of a fixed threshold, we establish a percent threshold based upon the percent of eligible cases in 2009. Another commenter suggested that if an eligible professional has an electronic prescribing system, he or she should be using the system for all prescriptions. Other commenters suggested a threshold of 250–500 electronic prescribing events during the reporting period.

Response: We appreciate the commenters' feedback, and believe that lowering this requirement simplifies the reporting burden, which would encourage more eligible professionals to participate in this incentive program, and more importantly, to adopt an electronic prescribing system.

We agree with commenters that some eligible professionals may be able to meet the criteria for successful reporting in a matter of a few days or weeks. However, in establishing the threshold of 25 electronic prescribing events, we also took into account the many valid circumstances that would prevent eligible professionals who have adopted a qualified electronic prescribing system from having 25 electronic prescribing events during the calendar year and variations in practice characteristics. In addition to the patient-related, system-related, or legal reasons that were formerly addressed by reporting the G8446 code for the measure, some eligible professionals may have few opportunities to report the electronic prescribing measure since they generate a low volume of prescriptions, have few Medicare patients, infrequently provide the services included in the measure's denominator, or a combination of these factors.

Comment: Other commenters were concerned that the proposed changes to the criteria for determining a successful electronic prescriber, while lower than the 2009 criteria, would make it more difficult to qualify for the electronic prescribing incentive payment. The commenters were concerned that the impact on eligible professionals will vary depending on the percentage of Medicare patients in their practice and the volume of prescriptions generated by the practice. For some practices 25 electronic prescriptions could be achieved in a matter of days but for

other practices it may be difficult or impossible to achieve this threshold. One commenter suggested that lowering the reporting threshold from 25 to 15 may be enough to get an eligible professional to adopt and use an electronic prescribing system and to recognize its superiority. Other commenters suggested that we retain the criteria to report the electronic prescribing measure on 50 percent of applicable cases instead.

Response: As we stated previously, we have taken the commenters' concerns into consideration in establishing the proposed threshold of 25 electronic prescribing events. On average, we believe an eligible professional would need to have 2 to 3 electronic prescribing events per month to be considered a successful electronic prescriber. We believe that this is achievable by a majority of eligible professionals. However, we will monitor the 2010 E-Prescribing Incentive Program results and take the commenters' recommendation into consideration as we develop the criteria for future years.

Comment: Some commenters recommended that we allow for alternative reporting to accommodate those who may not be able to electronically prescribe at least 25 times due to state or federal laws and regulations that do not allow electronic prescribing for narcotics or other controlled substances.

Response: As stated previously, we have taken into account the many valid circumstances that would prevent eligible professionals who have adopted a qualified electronic prescribing system from having 25 electronic prescribing events during the calendar year, including state or federal laws and regulations that do not allow electronic prescribing for narcotics or other controlled substances, when we established the proposed threshold of 25 electronic prescribing events. Therefore, we do not believe that it is necessary to establish alternative reporting criteria for such eligible professionals.

Comment: One commenter recommended that, for eligible professionals who practice in a nursing facility and other institutional settings, the determination of successful electronic prescriber should be made by measuring the electronic management of prescription drugs instead of measuring adoption and use of a qualified electronic prescribing system. The commenter recommends that eligible professionals be required to submit, with each eligible CPT code, a HCPCS code verifying that all prescription medications for the patient were electronically reviewed prior to the submission of the claims. This would continue to incentivize eligible professionals, who are prescribing schedule drugs, or working in a facility which does not provide access to electronic prescribing or the internet, for electronically managing patients' drugs.

Response: We are unclear as to how incentivizing eligible professionals for electronically managing patients' drugs encourages the adoption and use of electronic prescribing technology. In contrast, the proposed criteria for determining a successful electronic prescriber encourage the adoption and use of electronic prescribing technology by requiring eligible professionals to report to us that they have used a qualified electronic prescribing system during the reporting period. Therefore, we are not adopting the commenter's recommendation.

Comment: One commenter recommended that we institute a ''floor'' or minimum number of prescriptions that must be prescribed in order to even be assessed for the electronic prescribing incentive. This would protect consultants or proceduralists who do not prescribe medications from being assessed a payment adjustment in future years.

Response: We believe that such a floor is already addressed by the limitation required under section 1848(m)(2)(B) of the Act. In order to avoid being subject to the limitation for 2010 and qualify to earn an electronic prescribing incentive payment, eligible professionals who meet the criteria for successful electronic prescriber must have at least 10 percent of their Medicare Part B PFS allowed charges for covered professional services comprised of the codes in the denominator of the electronic prescribing measure. In addition, we note that under section 1848(m)(2)(B) of the Act, eligible professionals who are subject to the limitation would not be subject to the payment adjustment.

Comment: One commenter recommended that we apply the proposed criteria for determining a successful electronic prescriber for 2010 to the 2009 E-Prescribing Incentive Program so that those eligible professionals who reported that they electronically prescribed at least 25 times in 2009 would also be eligible to receive a 2009 electronic prescribing incentive payment.

Response: We do not have the authority to change the criteria for determining a successful electronic prescriber for 2009. Section 1848(m)(3)(D) of the Act does not authorize us to revise the criteria for submitting data on electronic prescribing measures specified under subparagraph (B)(ii) until years after 2009. Additionally, even if we had the authority to modify the criteria for determining a successful electronic prescriber for 2009, we could not do so retrospectively.

Comment: Some commenters urged us to use our authority under section 1848(m)(3)(B)(iv) of the Act to utilize Part D claims to determine if eligible professionals are prescribing a sufficient number of prescriptions electronically. The commenters noted that this would be a more efficient means of capturing the information needed by us for determining whether an eligible professional is a successful electronic prescriber. One commenter stressed that it is necessary for us to overcome our concerns about the use of a certain number of Part D prescribing events as a basis for the incentive payment in time for implementation of the meaningful use criteria in 2011.

Response: We agree that using Part D claims to determine if eligible professionals are prescribing a sufficient number of prescriptions electronically could potentially be a more efficient means of capturing the information needed by us for determining whether an eligible professional is a successful electronic prescriber and we anticipate that we would do so as soon as it is practical to do so. As we stated in the CY 2010 PFS proposed rule (74 FR 33595), however, the accuracy and completeness of the Part D data with respect to whether a prescription was submitted electronically by an individual eligible professional is unknown since that information will not be collected on the Part D claims, until 2010. During 2010 we anticipate evaluating the adequacy of Part D data to determine the feasibility of its use for determining whether an eligible professional qualifies as a successful electronic prescriber. In the meantime, we are implementing alternative reporting mechanisms (that is, registry and EHR reporting) for reporting the electronic prescribing measure in 2010 in an effort to provide more flexibility to eligible professionals.

After considering the comments, for 2010, an eligible professional will be required to report the electronic prescribing measure at least 25 times during the reporting period for purposes of meeting the criteria for successful electronic prescriber and qualifying to earn the electronic prescribing incentive (subject to the limitation required under section 1848(m)(2)(B) of the Act). In other words, an eligible professional will be required to report that he or she

electronically prescribed at least 25 times during the reporting period for services indicated by one of the codes included in the measure's denominator.

As stated previously, by December 31, 2009, we will post the final specifications of the measure on the ''E-Prescribing Measure'' page of the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive*.

d. Determination of the 2010 Incentive Payment Amount for Individual Eligible Professionals Who Are Successful Electronic Prescribers

Section 1848(m)(2)(B) of the Act imposes a limitation on the electronic prescribing incentive payment. The Secretary is authorized to choose 1 of 2 possible criteria for determining whether or not the limitation applies to a successful electronic prescriber. The first criterion, under section 1848(m)(2)(B)(i) of the Act, is based upon whether the Medicare Part B allowed charges for covered professional services to which the electronic prescribing quality measure applies are less than 10 percent of the total Medicare Part B PFS allowed charges for all covered professional services furnished by the eligible professional during the reporting period. The second criterion, under section 1848(m)(2)(B)(ii) of the Act, is based on whether the eligible professional submits (both electronically and nonelectronically) a sufficient number (as determined by the Secretary) of prescriptions under Part D (which can, again, be assessed using Part D drug claims data). If the Secretary decides to use the latter criterion, then, in accordance with section 1848(m)(2)(B) of the Act, the criterion based on the reporting on electronic prescribing measures would no longer apply. The statutory limitation also applies with regard to the future application of the payment adjustment.

Based on our proposal to make the determination of whether an eligible professional is a ''successful electronic prescriber'' based on submission of the electronic prescribing measure, we proposed to apply the criterion under section 1848(m)(2)(B)(i) of the Act for the limitation for the 2010 E-Prescribing Incentive Program.

The following is a summary of the comments we received regarding the proposed criterion for the limitation.

Comment: Although the commenters acknowledged that the limitation on the electronic prescribing incentive payment is required by law, a few commenters were opposed to the 10 percent threshold because certain types of eligible professionals would be unlikely to meet the 10 percent threshold.

Response: Unfortunately, we do not have the authority to change the 10 percent threshold, since the threshold is required by section 1848(m)(2)(B)(i) of the Act. In an effort to allow more eligible professionals to potentially qualify for the incentive payment, however, we have expanded the denominator of the electronic prescribing measure. Despite the requirement that 10 percent or more of an eligible professional's charges must be comprised of codes in the denominator, preliminary information from the 2009 E-Prescribing Incentive Program indicates that over 90 percent of eligible professionals who have prescribing privileges do not appear to be affected by the limitation. We believe that expanding the denominator of the measure will further reduce the percentage of eligible professionals who will be subject to the limitation.

Comment: One commenter requested that we make available to individual eligible professionals the percentage of their prior year's Medicare charges that resulted from the codes included in the electronic prescribing measure's denominator specifications since many eligible professionals may not have the time or analytic tools necessary to make the determination of whether they are likely to meet the 10 percent threshold prior to making the decision on whether to electronically prescribe.

Response: Unfortunately, we do not have the resources to calculate and provide feedback to eligible professionals regarding the composition of their charges. Most electronic billing systems, however, will have this functionality and should be able to provide eligible professionals who use such billing systems with this information.

Since, as discussed above, we are finalizing for 2010 our proposal to make the determination of whether an eligible professional is a ''successful electronic prescriber'' based on submission of the electronic prescribing measure, we also are finalizing our proposal to analyze the claims submitted by the eligible professional at the TIN/NPI level to determine whether the 10 percent threshold is met in determining the receipt of an electronic prescribing incentive payment for 2010 by an eligible professional. This calculation is expected to take place in the first quarter of 2011 and will be performed by dividing the eligible professional's total 2010 Medicare Part B PFS allowed charges for all such covered professional services submitted for the measure's denominator codes by the eligible professional's total Medicare Part B PFS allowed charges for all covered professional services (as assessed at the TIN/NPI level). If the result is 10 percent or more, then the statutory limitation will not apply and a successful electronic prescriber will qualify to earn the electronic prescribing incentive payment. If the result is less than 10 percent, then the statutory limitation will apply and the eligible professional will not earn an electronic prescribing incentive payment—even if he or she electronically prescribes and reports a G-code indicating that he or she generated and transmitted a prescription electronically at least 25 times for those eligible cases that occur during the 2010 reporting period. Although an individual eligible professional may decide to conduct his or her own assessment of how likely this statutory limitation is expected to apply to him or her before deciding whether or not to report the electronic prescribing measure, an individual eligible professional may report the electronic prescribing measure without regard to the statutory limitation for the incentive payment.

e. Reporting Option for Satisfactory Reporting of the Electronic Prescribing Measure by Group Practices

In the CY 2010 PFS proposed rule (74 FR 33599 through 33600), we discussed making incentive payments to group practices based on the determination that the group practice, as a whole (that is, the TIN), is a successful electronic prescriber for 2010, as required under section 1848(m)(3)(C)(i) of the Act. In addition, we noted that section 1848(m)(3)(C)(iii) of the Act requires that payments to a group practice by reason of the process established under section 1848(m)(3)(C)(i) of the Act shall be in lieu of the payments that would otherwise be made under this subsection to eligible professionals in the group practice for being a successful electronic prescriber.

(1) Definition of ''Group Practice''

Section 1848(m)(3)(C)(i) of the Act authorizes the Secretary to define ''group practice.'' For purposes of determining whether a group practice is a successful electronic prescriber, we proposed that a ''group practice'' would consist of a physician group practice, as defined by a TIN, with at least 200 or more individual eligible professionals (or, NPIs) who have reassigned their billing rights to the TIN (74 FR 33599). In addition, we proposed to limit the group practices eligible to participate in the 2010 E-Prescribing Incentive

Program through the group practice reporting option to those group practices selected to participate in the PQRI group practice reporting option.

The following is a summary of the comments received regarding our proposed definition of ''group practice''.

Comment: Several commenters urged CMS to permit small and mid-sized group practices with fewer than 200 eligible professionals to participate in the group practice reporting option. One commenter requested that we reconsider the 200 individual eligible professional thresholds for the definition of a group practice or that we at least offer an alternative reporting option that uses a statistical sampling model for primary care oriented group practices.

Response: We recognize that the proposed required group practice size of 200 or more individual eligible professionals limits participation. As stated in the proposed rule (74 FR 33599), for 2010, we would like to limit the number of groups participating in the group practice reporting option until we get further experience with the group practice reporting option. Therefore, we are not adopting the commenters' suggestion to permit small and mid-sized group practices with fewer than 200 eligible professionals to participate in the group practice reporting option and are finalizing the definition of ''group practice'' for the electronic prescribing group practice reporting option as proposed.

In order for a group practice to participate in the electronic prescribing group practice reporting option for 2010, the group practice must be one that is selected to participate in the PQRI group practice reporting option, which requires that group practices have 200 or more eligible professionals. Group practices cannot solely participate in the electronic prescribing group practice reporting option. A group practice can choose to participate in: (1) both the PQRI group practice reporting option and the electronic prescribing group practice reporting option; (2) the PQRI group practice reporting option but participate in the E-Prescribing Incentive Program as individual eligible professionals; or (3) the PQRI group practice reporting option but not participate in the E-Prescribing Incentive Program at all.

We will use this initial implementation year to explore and refine the group practice reporting option and anticipate expanding this option to group practices with less than 200 individual eligible professionals in future program years.

Comment: A commenter urged us to keep PQRI and the E-Prescribing Incentive programs separate and distinct for group practices wishing to participate in the PQRI group practice reporting option.

Response: The PQRI and E-Prescribing Incentive Programs are separate and distinct incentive programs with different program requirements. However, in order for a group practice to participate in the electronic prescribing group practice reporting option, one of the participation requirements is that the group practice must be one that is selected to participate in the PQRI group practice reporting option. As stated previously, a group practice can choose to participate in: (1) Both the PQRI group practice reporting option and the electronic prescribing group practice reporting option; (2) the PQRI group practice reporting option but participate in the E-Prescribing Incentive Program as individual eligible professionals; or (3) the PQRI group practice reporting option but not participate in the E-Prescribing Incentive Program at all. Therefore, participation in the E-Prescribing Incentive Program, whether as a group practice or at the individual eligible professional level, is optional for those group practices selected to participate in the PQRI group practice reporting option.

For those group practices who choose to participate in both the PQRI and electronic prescribing group practice reporting option, it is important to note that the electronic prescribing measure is not reportable using the PQRI group practice reporting option data collection tool. The electronic prescribing measure is reportable via the same reporting mechanisms that are available to individual eligible professionals participating in the 2010 E-Prescribing Incentive Program (that is claims, a qualified registry, or a qualified EHR).

Comment: A commenter had concerns that some group practices will have difficulty ramping up for participation in both the PQRI and electronic prescribing group practice reporting options between now and January 1, 2010.

Response: As we stated previously, participation in the electronic prescribing group practice reporting option by group practices selected to participate in the PQRI group practice reporting option is optional. To the extent that a group practice chooses to participate in both programs' group practice reporting options, it does not need to be ready to begin the PQRI and electronic prescribing group practice reporting options between now and January 1, 2010. As stated in section II.G.2. of this final rule with comment period, we are requiring interested group practices that meet the criteria to self-nominate by January 31, 2010 and indicate to us whether the practice wishes to participate in just the PQRI group practice reporting option or both the PQRI and electronic prescribing group practice reporting option. The reporting periods for both programs are the same (that is, January 1, 2010 through December 31, 2010), the data submission timelines, however, are different.

In an attempt to ensure the group practices have sufficient time to become acclimated to the PQRI group practice reporting option, for the 2010 PQRI, the group practice will be notified of the selection decision to participate in the PQRI group practice reporting option no later than the second quarter of 2010. Training on the data collection tool is projected to be provided in the third quarter of 2010. The group practice will not be expected to complete and return the data collection tool until the end of the first quarter of 2011.

For the 2010 E-Prescribing Incentive Program, we proposed requiring that reporting of the electronic prescribing measure by group practices would occur under the same data submission timeline as reporting of the electronic prescribing measure by individual eligible professionals. The proposed reporting mechanisms for the electronic prescribing measure would be the same regardless of whether an eligible professional is participating individually or as a group practice. Furthermore, the electronic prescribing measure was not proposed to be reportable via the PQRI group practice reporting option data collection tool.

To summarize, based on these comments, for purposes of the 2010 E-Prescribing Incentive Program, we are finalizing a group practice reporting option that will consist of ''group practice'' being defined as a TIN with at least 200 or more individual eligible professionals (as identified by NPIs) who have reassigned their billing rights to the TIN and who are participating in the 2010 PQRI group practice reporting option. Therefore, unlike individual eligible professionals who are not required to participate in the PQRI, to be eligible to earn an electronic prescribing incentive in 2010, group practices that wish to participate in the electronic prescribing group practice reporting option will be required to participate in the PQRI group practice reporting option. Participation in the E-Prescribing Incentive Program, including participation in the electronic prescribing group practice reporting option is, however, optional for group

practices that are participating in PQRI under the group practice reporting option. If a group practice wishes to participate in the 2010 E-Prescribing Incentive Program under the group practice reporting option, it must indicate its desire to do so at the time that the group practice self-nominates to participate in the 2010 PQRI group practice reporting option. There is no need for group practices to indicate their intent to participate in the 2010 E-Prescribing Incentive Program as individual eligible professionals when the group practice self-nominates to participate in the 2010 PQRI group practice reporting option.

Group practices interested in participating in the 2010 PQRI through the group practice reporting option are required to submit a self-nomination letter to CMS, requesting to participate in the 2010 PQRI group practice reporting option. Instructions for submitting the self-nomination letter will be posted on the PQRI section of the CMS Web site by November 15, 2009. A group practice that wishes to participate in the E-Prescribing Incentive Program group practice reporting option will be notified of the selection decision to participate in the E-Prescribing Incentive Program at the same time that it is notified of the selection decision for the PQRI group practice reporting option.

In addition to meeting the eligibility requirements discussed in section II.G.5.e.1. of this final rule with comment period, a group practice that wishes to participate in the 2010 E-Prescribing Incentive Program under the group practice reporting option will also have to indicate how it intends to report the electronic prescribing measure. That is, the group practice will need to indicate in its self-nomination letter which reporting mechanism the group practice intends to use for purposes of participating in the 2010 E-Prescribing Incentive Program group practice reporting option.

(2) Process for Group Practices to Participate as Group Practices and Criteria for Successful Reporting of the Electronic Prescribing Measure by Group Practices

For group practices selected to participate in the electronic prescribing group practice reporting option for 2010, we proposed the reporting period would be January 1, 2010 to December 31, 2010 (74 FR 33599 through 33600).

We proposed that physician groups selected to participate in the 2010 E-Prescribing Incentive Program through the group practice reporting option would be able to choose to report the electronic prescribing measure through the claims-based, the registry-based, or, contingent upon us finalizing this reporting mechanism for the 2010 PQRI, the EHR-based reporting mechanism.

In order for a group practice to be considered a successful electronic prescriber, we proposed that the group practice would have to report that at least 1 prescription during an encounter was generated using a qualified electronic prescribing system in at least 2,500 instances during the reporting period. We solicited comments on the proposed criteria for determining whether a group practice is a successful electronic prescriber. We also invited feedback on our underlying assumptions.

Section 1848(m)(2)(B) of the Act specifies that the limitation on the applicability of the electronic prescribing incentive applies to group practices as well as individual eligible professionals. Therefore, in determining whether a group practice will receive an electronic prescribing incentive payment for 2010 by meeting the proposed reporting criteria described above, we would determine whether the 10 percent threshold is met based on the claims submitted by the group practice.

The following is a summary of the comments we received regarding the proposed process for group practices to participate as group practices and criteria for successful reporting of the electronic prescribing measure by group practices.

Comment: One commenter agrees with CMS' assumptions and proposals for group reporting and believed it is reasonable to set criteria for successful electronic prescribing using the 2,500 threshold. Conversely, one commenter believed that 2,500 electronic prescribing events during the reporting period is too low a threshold for group practices and suggested that the threshold should be 25,000 to 50,000 electronic prescribing instances during the reporting period per group practice. One commenter believed that CMS should retain the 50 percent rule and thinks that establishing a numerical target of 2,500 electronic prescribing instances during the reporting period creates an unbalanced incentive depending on practice type, size, and percent Medicare patient mix. Another commenter stated that the electronic prescribing group practice reporting option should not be different for a group practice versus an individual eligible professional.

Response: By establishing a reporting threshold of 2,500 electronic prescribing events per reporting period per group practice, we desired to implement a threshold that is obtainable and demonstrates that the group practice has adopted and is using a qualified electronic prescribing system. Also, by establishing this threshold, we sought to reduce reporting burden. A numerical target of reporting 2,500 electronic prescribing events per reporting period will provide a tangible goal for the group practices to achieve. As stated previously, we are making every effort to promote the adoption of electronic prescribing by making participation both practical and operational so that group practices may achieve successful reporting. In establishing the threshold of 2,500 electronic prescribing events, we had to take into account not only all the circumstances that we discussed above with respect to the threshold for individual eligible professionals that could prevent a group practice who has adopted a qualified electronic prescribing system from having 2,500 electronic prescribing events during the calendar year but also the fact that the impact of these circumstances will vary depending on the types of specialties that are affiliated with each group practice.

Comment: A commenter expressed that the proposed method of calculating whether the limitation applies to a group practice will prevent most large multi-specialty group practices from being able to use the electronic prescribing group practice reporting option.

Response: We do not have the authority to change the basis for determining the applicability of the limitation. If we are making the determination of successful electronic prescriber based on reporting the electronic prescribing measure, section 1848(m)(2)(B) of the Act specifies that the limitation will apply if the Medicare Part B PFS allowed charges for all covered professional services furnished by the group practice for the codes to which the electronic prescribing quality measure applies are less than 10 percent of the total of the Medicare Part B PFS allowed charges for all covered professional services furnished by the group practice.

For the reasons mentioned above and after considering the comments, we are finalizing for the 2010 E-Prescribing Incentive Program the group practice reporting option discussed above. Specifically, group practices will be required to report the 2010 electronic prescribing measure at least 2,500 times during the reporting period in order for the group practice to be considered a successful electronic prescriber.

Group practices will be able to choose to report the electronic prescribing

measure through claims, a qualified registry, or qualified EHR product. As discussed for individual eligible professionals, only registries and EHR products qualified to participate in the 2010 PQRI will be qualified for purposes of the 2010 electronic prescribing group practice reporting option.

In addition, in determining whether a group practice will receive an electronic prescribing incentive payment for 2010 by meeting the reporting criteria described above, we will determine whether the 10 percent threshold is met based on our analysis of the claims submitted by the group practice during the reporting period. This calculation is expected to take place in the first quarter of 2011 and will be determined by dividing the group practice's total 2010 Medicare Part B PFS allowed charges for all covered professional services submitted for the measure's denominator codes by the group practice's total Medicare Part B PFS allowed charges for all covered professional services. If the result is 10 percent or more, then the statutory limitation will not apply and a group practice that is determined to be a successful electronic prescriber will qualify to earn the electronic prescribing incentive payment. If the result is less than 10 percent, then the statutory limitation will apply and the group practice will not qualify to earn the electronic prescribing incentive payment.

f. Public Reporting of Names of Successful Electronic Prescribers

Section 1848(m)(5)(G) of the Act requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submit data on quality measures for the PQRI and the names of the eligible professionals (or group practices) who are successful electronic prescribers. As required by section 1848(m)(5)(G) of the Act, we proposed to make public the names of eligible professionals and group practices who are successful electronic prescribers for the 2010 E-Prescribing Incentive Program on the Physician and Other Health Care Professionals Directory.

The following is summary of the comments we received regarding requirements under section 1848(m)(5)(G) of the Act with respect to the E-Prescribing Incentive Program.

Comment: Some commenters supported public reporting of the names of successful electronic prescribers. One commenter, in particular, noted that public reporting of the names of successful electronic prescribers will assist health plans in identifying such entities for related requirements in Medicare Advantage and Part D and help private health plans identify those that may need to be encouraged or assisted with electronic prescribing.

Response: We are pleased to have commenters' support for our efforts to make information about eligible professionals' adoption and use of electronic prescribing technology publicly available. We agree that such information may be relevant and useful to a broad audience.

Comment: Many commenters urged us to post only the information required by section 1848(m)(5)(G) of the Act, that is, the names of individual eligible professionals and group practices who are successful electronic prescribers.

Response: As we stated in the CY 2010 PFS proposed rule (74 FR 33600), we proposed to make public only the names of eligible professionals and group practices who are successful electronic prescribers. We do not anticipate posting any other information with respect to the E-Prescribing Incentive Program at this time.

Comment: Other commenters recognized that we are statutorily required to carry out public reporting of the names of successful electronic prescribers but are, nevertheless, opposed to publicly releasing the names of successful electronic prescribers or urged us to delay releasing such information until the public has a better understanding of the details of the E-Prescribing Incentive Program. Some of the concerns specifically cited by commenters include the following:

- The E-Prescribing Incentive Program is voluntary and excludes many eligible professionals;
- A formal independent evaluation of the E-Prescribing Incentive Program's processes and an analysis and validation of the data gathered needs to be conducted prior to any information being publicly released;
- CMS needs to provide eligible professionals with better access and feedback to the quality data they report (especially feedback on why they failed to report successfully) before the release of any information;
- There is little to be gained from this effort since eligible professionals and patients do not fully understand the details of the program and are still learning about this program;
- Patients may not understand the purpose for posting this information since the program is still new; and
- The criteria for becoming a successful electronic prescriber are changing from 2009 to 2010.

Response: We are appreciative of the commenters' thoughtful and constructive feedback and will take these concerns into consideration as we further develop our plans for publicly reporting information from the E-Prescribing Incentive Program. While we understand the commenters' concerns, we note that section 1848(m)(5)(G) of the Act requires us to list the names of individual eligible professionals and group practices who are successful electronic prescribers in an easily understandable format on our Web site. As such, it is our intent to identify the eligible professionals and group practices who are successful electronic prescribers for the 2010 E-Prescribing Incentive Program for posting in 2011. We note that we anticipate conducting an evaluation of the E-Prescribing Incentive Program and making the national evaluation results public through an experience report similar to the ''PQRI 2007 Reporting Experience'' report that we posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportFinal12032008CSG.pdf*.

Comment: A few commenters stressed the importance of including appropriate and prominent disclaimers or other statements on our Web site that provides information about the E-Prescribing Incentive Program and specifically state that there are valid reasons why an eligible professional may not have been a successful electronic prescriber for 2010.

Response: We agree with the commenters on the importance of including disclaimers and other information on the Web site that explains the E-Prescribing Incentive Program and its goals and the limitations of the data being reported (such as the fact that there are valid reasons why an eligible professional may not have been a successful electronic prescriber). Thus, it is our intent to include such language and disclaimers on the Web site similar to what was displayed with the 2007 PQRI participation information that was publicly released on the Physician and Other Health Care Professionals Directory in December 2008. We also anticipate being able to update the Physician and Other Health Care Professionals Directory to display the relevant disclaimers more prominently.

Comment: Some commenters recommended that eligible professionals and group practices have an opportunity to review their electronic prescribing

results before those results are made public, including access to information about why they were not able to successfully report this data, and that we continue to work with eligible professionals on the sensitive issues that surround this concept.

Response: Eligible professionals and group practices will have an opportunity to review their electronic prescribing results via the detailed, confidential feedback reports that will be made available to all eligible professionals and group practices who participle in the E-Prescribing Incentive Program. Eligible professionals and group practices will have an opportunity to obtain their feedback reports prior to any information about their success being publicly released.

Eligible professionals who have concerns about their results or any other information included on their feedback reports are encouraged to contact the QualityNet Help Desk at (866) 288–8912 or *qnetsupport@sdps.org* for assistance.

Comment: One commenter recommended that we also publicly report the names of eligible professionals who choose to not participate in the E-Prescribing Incentive Program.

Response: We do not believe it will be meaningful to the public to know the names of those eligible professionals who choose not to participate in the E-Prescribing Incentive Program. As some commenters noted, the E-Prescribing Incentive Program is a voluntary incentive program and many eligible professionals who have adopted and use a qualified electronic system have valid reasons for not participating. For example, some eligible professionals may not provide the services included in the electronic prescribing measure's denominator and, therefore, would not have an opportunity to report the measure. Other professionals may know, based on the prior year's charges, that they are unlikely to meet the statutory limitation under section 1848(m)(2)(B) of the Act that would allow them to be eligible to qualify to earn the electronic prescribing incentive payment. Therefore, such eligible professionals would most likely opt to not participate in the E-Prescribing Incentive Program even if they are electronically prescribing.

After considering the comments, we will publicly report the names of eligible professionals and group practices who are successful electronic prescribers for the 2010 E-Prescribing Incentive Program on the Physician and Other Health Care Professionals Directory. We anticipate that the names of individual eligible professionals and group practices who are successful electronic prescribers for the 2010 E-Prescribing Incentive Program will be available in 2011 after the 2010 incentive payments are paid.

Although we stated in the CY 2009 PFS proposed rule (74 FR 33600) and the CY 2008 PFS final rule with comment period (73 FR 69852) that we intended to post the names of individual eligible professionals who meet the criteria for successful electronic prescriber and for whom the limitation does not apply (in other words, eligible professionals who qualify to earn an incentive payment), we would like to clarify that for purposes of publicly reporting the names of individual eligible professionals on the Physician and Other Health Care Professionals Directory, section 1848(m)(5)(G) of the Act requires only that the Secretary post the names of eligible professionals (or group practices) who are successful electronic prescribers. Therefore, with respect to the 2010 E-Prescribing Incentive Program we intend to post the names of individual eligible professionals who report the electronic prescribing measure at least 25 times during the 2010 reporting period for patient encounters included in the measure's denominator, without regard to whether the limitation applied to the eligible professional and without regard to whether the eligible professional actually qualified to earn an incentive payment. In addition, since the PQRI and the E-Prescribing Incentive Program are two separate incentive programs and individual eligible professionals are not required to participate in both programs to earn an incentive under either program, we point out that it is possible for an eligible professional who participates in both incentive programs to be listed both as an individual eligible professional who satisfactorily submits data on quality measures for the PQRI and is a successful electronic prescriber under the E-Prescribing Incentive Program. Likewise, an individual eligible professional may be listed as an individual eligible professional who satisfactorily submits data on quality measures for the PQRI but not as a successful electronic prescriber under the E-Prescribing Incentive Program (or vice versa) even if he or she participated in both incentive programs.

Similarly, for purposes of publicly reporting the names of group practices, on the Physician and Other Health Care Professionals Directory, we intend to post the names of group practices who report the electronic prescribing measure at least 2,500 times during the 2010 reporting period for patient encounters included in the measure's denominator without regard to whether the limitation applied to the group practice or whether the group practice actually qualified to earn an incentive payment. Although any group practice participating in the E-Prescribing Incentive Program under the group practice reporting option would have had to also participate in the PQRI group practice reporting option, the criteria for satisfactory reporting of PQRI measures for group practices are different from the criteria for successful reporting of the electronic prescribing measure by group practices. Therefore, it is possible for a group practice to be listed as a group practice that satisfactorily submits data on quality measures for the PQRI but not as a successful electronic prescriber under the E-Prescribing Incentive Program, or vice versa.

6. Section 135: Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services

Section 1834(e) of the Act, as added by section 135(a) of the MIPPA, requires that beginning January 1, 2012, Medicare payment may only be made for the technical component (TC) of advanced diagnostic imaging services for which payment is made under the fee schedule established in section 1848(b) of the Act to a supplier who is accredited by an accreditation organization (AO) designated by the Secretary.

a. Accreditation Requirement

In the proposed rule, we proposed criteria for designating organizations to accredit suppliers furnishing the TC of advanced diagnostic imaging services as specified in section 1834(e) of the Act. In addition, we proposed the required procedures to ensure that the criteria used by an AO meets minimum standards for each imaging modality in § 414.68.

We did not propose any substantive standards that suppliers furnishing the TC of advanced imaging would have to meet. We have chosen to utilize clinical guidelines that are already accepted by the experienced accreditation organizations already performing accreditation. We believe that the suppliers should be able to assimilate these new accreditation requirements very easily into their medical practice.

We will be designating organizations based on, at minimum, their ability to meet the requirements set forth in the statute. In addition, in this rule we have

described the components that any organization must have in order to be considered for designated status.

As proposed, the CMS-designated AO would apply standards that set qualifications for medical personnel who are not physicians but who furnish the TC. The standards would describe the qualifications and responsibilities of medical directors and supervising physicians. including the following: recognizing whether a particular medical director or supervising physician received training in advanced imaging services in a residency program; and has attained, through experience, the necessary expertise to be a medical director or supervising physician; has completed any continuing medical education courses related to advanced imaging services; or has met such other standards as the Secretary determines appropriate.

In addition, the standards would require suppliers to: (1) Establish and maintain a quality control program to ensure the technical quality of diagnostic images produced by the supplier; (2) ensure the equipment used meets performance specifications; and (3) ensure safety of personnel. While the statute authorizes the Secretary to establish as criteria for accreditation any other standards or procedures the Secretary determines appropriate, we did not propose to establish other standards or procedures.

In the proposed rule, we also stated that we expect to publish a notice to solicit applications from entities for the purposes of becoming a designated AO the same day that this final rule with comment period is issued. We still expect to meet the January 1, 2010 statutory deadline in order to designate organizations to accredit suppliers furnishing the TC of advanced diagnostic imaging services by waiving the 60-day delay in the imaging accreditation provisions in the final rule.

We believe that we have furnished enough detail in the proposed rule, in addition to receiving extensive comments from prospective AOs, so that AOs will find that 30 days is sufficient time to respond to the solicitation.

b. Accreditation for Suppliers

Section 1834(e) of the Act requires the Secretary to designate and approve AOs to accredit suppliers of the TC of advanced diagnostic imaging services. To promote consistency in accrediting providers and suppliers throughout the Medicare program, we proposed to review existing procedures for the application, selection, and oversight of AOs detailed at 42 CFR part 488, subparts A and D, and apply them (with appropriate revisions) to organizations accrediting suppliers of the TC of advanced diagnostic imaging services. We proposed modifications to the existing part 488 requirements to meet the specialized needs of the advanced imaging industry. These modifications would require an independent AO applying for approval as a designated AO to include in their application:

- A detailed description of how the organization's accreditation criteria satisfy the statutory standards at section 1834(e)(3) of the Act, specifically:
  + Qualifications of medical personnel who are not physicians and who furnish the TC of advanced diagnostic imaging services;
  + Qualifications and responsibilities of medical directors and supervising physicians, such as training in advanced diagnostic imaging services in a residency program, expertise obtained through experience, or continuing medical education courses;
  + Procedures to ensure the safety of persons who furnish the TC of advanced diagnostic imaging services and individuals to whom such services are furnished;
  + Procedures to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by the supplier.
- An agreement to conform accreditation requirements to any changes in Medicare statutory requirements in section 1834(e) of the Act.
- Information to demonstrate the AO's knowledge and experience in the advanced diagnostic imaging arena.
- The organization's proposed fees for accreditation for each modality in which the organization intends to offer accreditation and any plans for reducing the burden and cost of accreditation to small and rural suppliers.
- Any specific documentation requirements and attestations requested by CMS as a condition of designation under this part.

If, after review of an AO's submission of information, we determined that additional information was necessary to make a determination for approval or denial of the AO's application to be designated as an AO for suppliers of the TC of advanced diagnostic imaging services, the organization would be notified and afforded an opportunity to provide the additional information. We could visit the organization's offices to verify representations made by the organization in its application, including, but not limited to, review of documents and interviews with the organization's staff. The AO would receive a formal notice from CMS stating whether the request for designation was approved or denied. If approval was denied, the notice would include the basis for denial and outline the reconsideration procedures. We would make every effort to issue a final decision no more than 30 calendar days from the time the completed reapplication was received by CMS. An AO could withdraw its application for designation under section 1834(e) of the Act at any time before the formal notice of approval is received. An AO that was notified that its request for designation was denied could request reconsideration in accordance with § 488.201 through § 488.211 in Subpart D. Any AO whose request for designation was denied could resubmit its application if the organization (1) Revised its accreditation program to address the rationale for denial of its previous request; (2) provided reasonable assurance that its accredited companies meet applicable Medicare requirements; and (3) resubmitted the application in its entirety. If an AO requested a reconsideration of a denial, it could not submit a new application for the type of modality that is at issue in the reconsideration until the reconsideration was final.

A panel would evaluate all proposals from AOs seeking designation under section 1834(e) of the Act using existing CMS survey and certification processes, similar to those established at § 488.4.

c. Payment Rules for Suppliers of the TC of Advanced Diagnostic Imaging Services (§ 414.68)

We would implement at § 414.68 the statutory requirement of section 1834(e) of the Act that all suppliers of the TC of advanced diagnostic imaging services be accredited by a CMS-designated AO by January 1, 2012 for payments made under the fee schedule established under section 1848(b). In § 414.68(a), we proposed to define the following:

- ''Accredited supplier'' would mean a supplier that has been accredited by a CMS-approved AO.
- ''Advanced Diagnostic Imaging Services'' would mean diagnostic magnetic resonance imaging, computed tomography, nuclear medicine, and positron emission tomography. We did not propose to include other diagnostic imaging services in this definition under section 1834(e)(1)(B)(ii) of the Act.
- ''CMS-approved accreditation organization'' would mean an independent AO designated by CMS to perform the accreditation function established in section 1834(e) of the Act.

d. Ongoing Responsibilities of CMS–Approved Accreditation Organizations

We proposed to require a CMS-approved AO to perform several activities on an ongoing basis. The organization would provide to CMS in written form and on an ongoing basis all of the following:

- Copies of all accreditation surveys of specific suppliers along with any survey-related information that we may require (including corrective action plans and summaries of CMS requirements that were not met).
- Notice of all accreditation decisions.
- Notice of all complaints related to suppliers of the TC of advanced diagnostic imaging service.
- Information about any suppliers of the TC of advanced diagnostic imaging service for which the accrediting organization has denied the supplier's accreditation status.
- Notice of any proposed changes in its accreditation standards or requirements or survey process. If the organization implemented the changes before or without CMS approval, we could withdraw approval of the AO.
- Written notice of any deficiencies and adverse actions implemented by the CMS-approved AO against an accredited supplier of the TC of advanced diagnostic imaging within 2 days of identifying such deficiencies, if the deficiencies pose immediate jeopardy to a beneficiary or to the general public.
- Written notice of the withdrawal to all accredited suppliers within 10 days of CMS' notice to withdraw approval of the AO.
- Summary data specified by CMS related to the past year's accreditation activities and trends, on an annual basis.

In addition, the AO would permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

e. Continuing CMS Oversight of CMS–Approved Accreditation Organizations

We proposed to add § 414.68 to establish specific criteria and procedures for continuing oversight and for withdrawing approval of an approved AO.

(1) Validation Audits

We proposed to audit the accredited organizations in order to validate the survey accreditation process of approved AOs in the TC of advanced imaging. The audits would be conducted on a representative sample of suppliers who have been accredited by a particular accrediting organization or in response to allegations of supplier noncompliance with the standards. When conducted on a representative sample basis, we proposed that the audit would be comprehensive and address all of the standards or would focus on a specific standard in issue. When conducted in response to an allegation, we proposed to specify that the CMS team or our contractor would audit for any standard that we determined was related to the allegations. We also proposed to require a supplier selected for a validation audit to authorize the validation audit to occur and authorize the CMS team or our contractor to monitor the correction of any deficiencies found through the validation audit. If a supplier selected for a validation audit failed to comply with the requirements at § 414.68, the supplier would no longer meet the Medicare requirements and, under this proposal, the supplier's accreditation for the TC of the advanced medical imaging would be revoked.

We proposed that a CMS team or our contractor would conduct an audit of an accredited organization, examine the results of the AO's own survey procedure onsite, or observe the AO's survey, in order to validate the organization's accreditation process. At the conclusion of the review, we would identify any accreditation programs for which validation audit results indicated the following:

- A 10 percent or greater rate of disparity between findings by the AO and findings by CMS or our contractor on standards that did not constitute immediate jeopardy to patient health and safety if not met;
- Any disparity between findings by the AO and findings by CMS or our contractor on standards that constituted immediate jeopardy to patient health and safety if not met; or
- There were widespread or systemic problems in the organization's accreditation process such that the accreditation no longer provided assurance that suppliers met or exceeded the Medicare requirements, irrespective of the rate of disparity.

(2) Notice of Intent To Withdraw Approval for Designating Authority

As proposed, if a validation audit, onsite observation, or our concerns with the ethical conduct (that impacted the health and safety of the beneficiary) of an AO suggest that the AO was not meeting the requirements of § 414.68, we would provide the organization written notice of our intent to withdraw approval of the AO's designating authority.

(3) Withdrawal of Approval for Designating Authority

We proposed to withdraw approval of an AO at any time if we determined that:

- Accreditation by the organization no longer provided sufficient assurance that the suppliers of the TC of advanced imaging meet the requirements of section 1834(e) of the Act and the failure to meet those requirements could pose an immediate jeopardy to the health and safety of Medicare beneficiaries;
- Conditions at an imaging supplier accredited by an AO constituted a significant hazard to the public health; or
- The AO failed to meet its obligations for application and reapplication procedures.

(4) Reconsideration

We proposed to implement requirements similar to those set out under 42 CFR part 488 without substantive changes, as the requirements have been utilized for the health care providers covered under 42 CFR part 488 since 1992. We proposed that an AO dissatisfied with a determination that its accreditation requirements did not provide or do not continue to provide reasonable assurance that the suppliers accredited by the AO met the applicable standards would be entitled to a reconsideration. We also proposed to reconsider any determination to deny, remove, or not renew the approval of the designating authority to AOs if the AO filed a written request for reconsideration through its authorized officials or through its legal representative.

We proposed to require the AO to file the request for reconsideration within 30 calendar days after the issuance of CMS notice of an adverse determination or non-renewal. We proposed to require the request for reconsideration to specify the findings or issues with which the AO disagreed and the reasons for the disagreement. A requestor could withdraw its request for reconsideration at any time before the issuance of a reconsideration determination. In response to a request for reconsideration, we would provide the accrediting organization the opportunity for an informal hearing that would be conducted by a hearing officer appointed by the CMS Administrator and provide the accrediting organization the opportunity to present, in writing and in person, evidence or documentation to refute the determination to deny approval, or to withdraw or not renew its designating authority.

As proposed, we would provide written notice of the time and place of the informal hearing at least 10 business days before the scheduled date. The informal reconsideration hearing would be open to CMS and the organization requesting the reconsideration, including authorized representatives, technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts), and legal counsel. The hearing would be conducted by the hearing officer, who would receive testimony and documents related to the proposed action. Testimony and other evidence could be accepted by the hearing officer. However, the normal evidentiary exclusions applicable in Federal courts would not apply to these hearings. The hearing officer would not have the authority to compel by subpoena the production of witnesses, papers, or other evidence. Within 45 calendar days of the close of the hearing, the hearing officer would present the findings and recommendations to the accrediting organization that requested the reconsideration. The written report of the hearing officer would include separate numbered findings of fact and the legal conclusions of the hearing officer. The hearing officer's decision would be final.

The following is a summary of the comments we received regarding our proposals for implementation of section 135 of MIPPA.

Comment: One commenter requested that we consider medical directors and supervising physicians to be equivalent positions, as they are frequently the same.

Response: We agree and have revised the regulation text accordingly at § 414.68(c)(1)(ii) to reflect that the clinical responsibilities of the medical director and/or supervising physician would be identical.

Comment: Some commenters stated that the physician should be qualified in the modality for which the supplier is applying. In order to ensure this compliance, one commenter suggested requiring billing under the NPI of that qualified physician and not another physician, which is commonly done to avoid self-referral provisions. Another commenter stated that we need to consider that any licensed physician, not just a radiologist who can respond to a patient's possible contrast reaction, be qualified as supervising medical directors and supervising physicians. The commenter also suggested that there be a degree of control over documented quarterly on-site interactions with nonphysician staff, creation and review of all imaging protocols along with developing quality performance guidelines as opposed to limiting the number of sites that the physician may serve as the medical director or supervising physician. The teleradiology area also needs to be included supervision performance criteria.

Response: We will develop billing policies connected to the provision of the TC of advanced subsequent to the issuance of this rule, and will take the commenters' concerns under advisement. With respect to performance measures for the Medical director and/or supervising physician, we expect that all AOs will consider performance measures in their credentialing and competency evaluations.

Comment: Some commenters stated that each designated AO should be required to evaluate the image quality produced as part of the AO's accreditation survey review process and that the accreditation personnel should have 5 years of specific documented experience and training in image acquisition and interpretation.

Response: We agree that experience in the advanced imaging area is important. For example, we are aware that some organizations require that accreditation personnel should have specific documented experience and training in image acquisition and interpretation for 5 years. CMS will review the standards for all potential accrediting organizations to determine whether it is necessary for CMS to impose a similar requirement. We intend to evaluate all accreditation organization applications based on documented evidence of having a level of experience in accrediting advanced imaging suppliers and the requirements for their surveyors who are completing these surveys.

Comment: One commenter requested that since the timeframe before the January 1, 2010 designation deadline was so near, the accompanying request for proposals should be on review prior to the display date of this final rule.

Response: Since the notice could have changed up to the display date of the final rule, we did not believe publishing a draft notice would have been helpful. We did, however, include all of the requirements in the proposed rule that we intended for the solicitation notice.

Comment: Some commenters believe that the proposed provision that exists for equipment review is not specific enough to guarantee a thorough evaluation of equipment performance and safety.

Response: We will revise our rule in § 414.68 to require that the equipment used by advanced imaging suppliers must meet the manufacturer's performance specifications.

Comment: Some commenters stated the quality of the supplier cannot adequately be assessed without a comprehensive evaluation of all aspects of the imaging service's operation, including personnel, image acquisition and quality, and the quality of the final report.

Response: We agree that all of these components are necessary in the evaluation of a TC supplier. We will be evaluating AOs' applications based on the performance standards that are used to make certain that these assessments are comprehensive.

Comment: One commenter requested clarification as to whether the proposed rules meant that advanced imaging standards could be lowered by CMS. If CMS changes its standards, the AO's experts should be given an opportunity to comment. The commenter also asked whether AOs could maintain or adopt standards that were more stringent than those required by CMS.

Response: Section 1834(e) of the Act, as added by section 135(a) of the MIPPA, requires that the Secretary consult with physician specialties and other stakeholders on provisions in this rule. We plan to do this, as required by the statute. Accreditation organizations may enforce the guidelines to be issued by CMS, or adopt standards that are more stringent than those Medicare requires.

Comment: Some commenters asked about the fee structure of the designated AOs. One commenter suggested that CMS assist small and rural suppliers, and that the fees be based on the number of imaging machines, number of testing modalities, and the number of testing sites. Another commenter stated the AOs should be allowed to use their differing methodologies for reducing accreditation costs for small and rural suppliers. The commenter believed that CMS was going to mandate the fee structure for the designated AO. One commenter suggested that we clarify the $5,000 cost per 3-year review cycle as an estimate of the cost per modality. One commenter stated that they were confused by what CMS intended the difference to be between small and specialty suppliers as compared to small and rural suppliers.

Response: We will be evaluating applications from all AOs that apply, and make certain that all have provisions for small and rural suppliers. Although we will not be prescribing the fee structure for the designated AO, we want to see that each application has a policy and procedure to determine cost and assistance that would take the

smallest supplier into consideration. As a clarification, note that this rule only applies to those specialty suppliers furnishing the TC of advance medical imaging.

Comment: Two commenters asked about unannounced site visits. There was concern that the site may either not have the appropriate staff for the modality, or in the case of a mobile unit, may not be present on the day the surveyor arrives. It was suggested that either the site visits were announced or that accrediting organizations utilize a combination of announced and unannounced surveys.

Response: We believe that a supplier who ''gets ready'' for the site survey is a supplier that is not providing quality care and services throughout the year. The supplier knows that a surveyor will be onsite every 3 years and thus would already be aware of an imminent survey.

Comment: Two commenters strongly encouraged that we include other diagnostic imaging services, such as ultrasound, to be eligible for accreditation.

Response: Section 1834(e)(1)(B)(ii) of the Act, as added by section 135(a) of MIPPA, specifically excludes X-ray, ultrasound, and fluoroscopy from those diagnostic imaging services subject to the accreditation requirement. Therefore, we cannot implement this change without Congressional action.

Comment: One comment discussed the transfer of individually identifiable health information and other information not intended for public disclosure. The commenter requested that we clarify under what circumstances such information would need to be transmitted and how that information would be safeguarded.

Response: Under normal circumstances, neither CMS or an AO would need to transfer individually-identifiable personal health information from one location to another. If, however, we need such information for investigational purposes it would either be transmitted via securely or de-identified prior to transmission.

Comment: One commenter requested clarification on the requirement that the AO notify Medicare of accreditation decisions to be intended for only those imaging suppliers that bill Medicare.

Response: We will provide that clarification. The requirement that the AO notify Medicare is only required for those suppliers billing Medicare.

Comment: Regarding the complaint reporting process, one suggested that the rule was not clear if the complaints that were to be reported were with respect to the AO or to the TC supplier being accredited. Another commenter suggested that we specify the frequency with which we expected accrediting organizations to report complaints about suppliers. The commenter also suggested that we specify the types of complaints about suppliers that would be subject to the reporting requirement. The commenter suggested that such conditions include: poor image quality, injury or harm from equipment, falsely claiming to be accredited, unqualified personnel, submission of false or misleading accreditation information. One commenter suggested that we change from 2 calendar days to 2 business days the proposed requirement that an AO notify CMS when it finds deficiencies in a TC supplier that pose an immediate jeopardy to the health and safety of patients receiving services from such supplier. One commenter also requested clarification of what was meant by ''appropriate licensing bodies,'' since there are specific State departments that control these entities.

Response: We agree with the commenter that we needed to clarify the applicability of the complaint reporting requirement. Therefore, we are clarifying in this final rule that the complaint process is applicable to any complaints that come from any source against an accredited supplier. We also agree that the reporting of complaints about conditions that pose immediate jeopardy to Medicare beneficiaries or the general public should be reported to CMS within 2 business days, because. Therefore, we are also amending § 414.68(c)(12)(iii)(G) to state that an approved AO will be required to notify CMS within 2 business days of such ''immediate jeopardy'' situations. Subsequent to the issuance of this rule, we will issue subregulatory guidance with respect to the frequency and types of other reporting that are necessary. In response to the commenter's inquiry, we are also noting that in the context of this final rule, ''Appropriate licensing body'' means any regulatory body, including State Radiation Control departments and the Nuclear Regulatory Commission.

Comment: Regarding circumstances in which CMS might withdraw its approval of an accrediting organization (thus requiring suppliers accredited by such organization to obtain new accreditation), two commenters suggested the final rule recognize that CMS and the remaining AOs would need to collaborate in order to distribute such affected suppliers among other accrediting organizations over a reasonable time period.

Response: We agree. It certainly is our expectation that any supplier transition process of this sort would be transparent, so that no disruption in patient care would occur.

Comment: One commenter stated that the proposal included hospitals in the summary data from the CMS' Services Tracking and Reporting System. Since the hospitals are not included in this proposal, the commenter requested reconfirmation that the provisions do not apply to hospitals.

Response: In § 414.68(a), in conformity with section 1834(e), we state that the imaging accreditation requirement applies only to suppliers of the TC of advanced diagnostic imaging services for which payment is made under the physician fee schedule. Since hospitals generally are not paid pursuant to such schedule, this accreditation rule is inapplicable. Hospitals, including their inpatient radiology departments, are accredited under 42 CFR part 488.

Comment: Two commenters suggested that instead of notifying CMS of all revisions to their accreditation requirements, standards and policies, as set out at proposed § 414.68(c)(12)(iii)(E) and § 414.68(d)(1)(v), accrediting organizations notify CMS only of major revisions to their respective accreditation standards or requirements or survey processes. In this context, ''major'' would be defined as ''changes having potential impact on the supplier's ability to maintain compliance with the standards or application process.''

Response: We agree; we will clarify our language to indicate that ''major changes'' mean only significant changes from what CMS approved in the AO's initial approved application.

Comment: Several commenters had questions about the proposed CMS audits of AOs. The commenters would like to have more information about the procedures that CMS surveyors would use. The commenters also stated that the meaning of the ''10 percent disparity rate'' was not clear. One commenter asked that we clarify who would bear the cost for a validation survey, what specific information would be collected in such surveys, and what percentage of sites would be surveyed.

Response: We will provide information on those specific procedures and criteria as they are developed. The 10 percent disparity rate is meant to be that of a single survey since it is important to CMS that each supplier is furnishing all of the standards as intended in a quality manner. CMS pays for these validation surveys.

Comment: One commenter requested clarification on how CMS would determine whether an AO was capable

of making ''timely reviews'' under proposed § 414.68(c)(6)(ii).

Response: We would consider an AO to be making timely reviews of suppliers' applications if the accrediting organization presented evidence that it could conduct such reviews in an orderly manner, and that all suppliers' applications would be judged uniformly and fairly, while still meeting the January 1, 2012 statutory deadline.

Comment: Two commenters asked about how AOs would prioritize suppliers in order to meet the January 1, 2012 deadline. The commenters believe that this practice would mean that some suppliers would have a preferential priority. The commenter believes that application processing order should instead be based upon the date the supplier submits its application to the accrediting organization. The commenters went on to state that CMS should inform suppliers of the application requirements so that all suppliers can be accredited by the January 1, 2012 deadline.

Response: While we agree with the commenters regarding education of all suppliers, we believe that the intent of the statute was that beneficiary services not be affected by any supplier not having the opportunity to meet all of the accreditation requirements. We will give guidance to the designated AOs so that there is a timely review of all existing suppliers.

Comment: Two commenters expressed concern over how new suppliers after January 1, 2012 would be able to bill for the TC of advanced imaging if they had not yet been accredited. One commenter wanted CMS to continue to allow those new suppliers the ability to bill up to nine months after January 1, 2012, as long as the new supplier was undergoing part of the accreditation process or received a provisional accreditation.

Response: We do not have the statutory authority to extend the billing privileges past the statutory deadline of January 1, 2012. We believe that there will not be any disruption to beneficiary services, as there are sufficient existing suppliers to furnish the TC of advanced diagnostic imaging services.

Comment: One commenter requested clarification regarding the treatment of suppliers accredited prior to January 1, 2012 as meeting the statutory requirements for accreditation. The commenter stated that the proposed rule could be interpreted to mean that any supplier accredited at any time prior to January 1, 2010 would be considered accredited regardless of their current status which could include their accreditation having previously expired, been revoked, or denied.

Response: Only those suppliers that have a current, unexpired accreditation as of January 1, 2012 will be deemed grandfathered with respect to the January 1, 2012 requirement.

Comment: One commenter requested that CMS require that AOs report not only revoked, withdrawn or revised accreditation decisions, but also include those accreditations that have expired, closed, or ceased providing that modality. The commenter suggested that this report be in an Excel file format and on a daily basis. The commenter also stated that if CMS reviewed copies of all survey materials and corrective action it would overwhelm the agency.

Response: We will require all accreditation decisions to be reported, including revocation and expiration of accreditation. We will require the accrediting organizations to include in their ongoing data the accreditation status of all of their suppliers, which includes the effective expiration dates and any changes to that accreditation status. We generally will not review individual suppliers' survey reports or corrective action plans unless there is a particular reason for us to do so. We will consider the most effective method of data collection.

Comment: One commenter suggested that CMS require a supplier to inform its AO if it ceases providing advanced diagnostic imaging services; to arrange transfer of each patient's medical record to a subsequent receiving supplier; to provide information to patients on how they can obtain their personal medical records; and to comply with any State or local requirements for such a record transfer.

Response: We agree with the commenter and are taking the suggestion. We will require a supplier to assist beneficiaries or their legal representative, in obtaining their records if requested, and notify the supplier's AO of any changes to the modalities being furnished at the time the accreditation decision is made.

Comment: One commenter requested that CMS clarify whether the orientation and in-service requirements in the proposed rule relate to the supplier or the AO. The commenter suggested that CMS should require AOs to direct the orientation and in-service programs toward image quality reviewers and on site surveyors.

Response: We will be reviewing all proposals to make certain that all approved AOs have robust orientation and in-service programs. Those programs should standardize the supplier review process and produce consistent quality surveys in both desk reviews and site surveys.

Comment: Regarding the annual summary data specified by CMS, one commenter suggested the data include the total number of sites and units applied and accredited; pass/fail rates by modality; results of any appeals by modality; number and reasons for any suspensions/revocations of accreditation overall and by modality; number and summary results of on-site surveys over and by category (random, scheduled, targeted and validation); surveyor resources available; any new surveyor training and summary of all complaints overall and by modality, including category and resolution.

Response: We will work with the designated AOs to develop annual reports that meet the needs of our stakeholders and the general public.

Comment: One commenter stated that CMS needs to develop a system for communicating the supplier's accreditation status to the Medicare contractors so that there are no claims denial errors. The commenter suggested the system to be updated on a daily basis. The commenter also suggested CMS institute a vigorous training program for local contractor staff.

Response: We will look into the necessity and feasibility of daily feeds to the contractor. Since CMS already has a comprehensive education program for our contractors, we will use the existing methods for educating all of our contractor staffs.

Comment: One commenter requested clarification regarding what format CMS is proposing to require when AOs provide information to CMS.

Response: We intend the written format to be via electronic submission in most cases. In those cases where Protected Health Information (PHI) needs to be transmitted by the AO, data files will be encrypted.

Comment: One commenter suggested that, instead of CMS instituting a formal re-application process for AOs, CMS could renew an AO's deeming authority on the basis of good standing. CMS could consider the AO's annual report, any validation survey findings, and other ongoing compliance instead of requiring a formal reapplication process. If CMS decided that a formal reapplication process were to be retained, the commenter suggested that CMS follow the precedent set by the Mammography Quality Standards Act (MQSA) for their approved accrediting bodies and set a seven year interval.

Response: We may consider such a suggestion. We do not believe that we would need to publish proposed

rulemaking in order to implement a formal re-application process.

Comment: One commenter asked CMS to clarify whether suppliers would still need to renew their accreditations under the timeframes of their designated AOs from January 1, 2010 to January 1, 2012.

Response: An accredited supplier would still need to renew its accreditation pursuant to the timeframe of its designated AO between January 1, 2010 and January 1, 2012. We believe it was the Congress' intent under section 1834(e)(5) of the Act that all suppliers accredited before January 1, 2010 by an accreditation organization designated on that date, be ''grandfathered'' with respect to the effectiveness of their accreditations. In other words, a supplier accredited by a designated AO as of January 1, 2010 would not need to be reaccredited subsequent to the AO's designation by CMS until the supplier's term of accreditation expired. However, this does not mean that a supplier can let its accreditation lapse between 2010 and 2012. Once a reaccreditation deadline has passed without reaccreditation, the supplier would no longer be considered accredited.

Comment: One commenter stated that CMS needs to consider the administrative time involved in obtaining precertification for Computerized Tomography (CT) of the head, ear, and maxilla facial area when determining the cost of these services. The technician's time involved in performing daily quality control testing to satisfy quality assurance requirements for accreditation and the physician time spent in quality assurance committee meetings to evaluate the images and reports has greatly increased the cost of providing in-office CT imaging. Another commenter stated that operating a certified imaging laboratory with methodology and protocols to the highest standards translates into increased costs for each study.

Response: Based on supplier interviews, maintaining the accreditation requirement has resulted in suppliers having opportunities to work more efficiently and effectively, thereby reducing the overall administrative costs per hour.

Comment: One commenter stated that the anticipated impact of implementation of accreditation standards for suppliers of the TC of advanced diagnostic imaging on family physicians would be minimal. The commenter supported the proposed accreditation requirements.

Response: We thank the commenters for the comment.

Comment: One commenter requested that CMS revise the supervision level requirement for certain CPT codes when these services are performed with assistance by the Registered Radiologist Assistant.

Response: We appreciate the information provided by the commenters as it will assist in understanding the role these individuals play in the provision of imaging services.

f. Other Issues for Consideration

In the proposed rule, we solicited information on the role of radiology assistants (RA) and radiology practitioner assistants (RPA), including the level of physician supervision that would be appropriate when RAs and RPAs are involved in the performance of the TC of advanced medical imaging, whether the role varies by State, and related information.

Comment: Commenters provided information concerning information on the role of radiology assistants and radiology practitioner assistants in the performance of the TC of advanced medical imaging in response to our request.

Response: We appreciate the information provided by the commenters as it will assist in understanding the role these individuals play in the provision of imaging services.

g. Provisions of the Final Rule

After reviewing the public comments, we are finalizing the accreditation provisions of the CY 2010 PFS proposed rule as follows:

- Clarifying that the—
  - ++ Medical directors and supervising physicians are equivalent positions;
  - ++ Equipment used by the supplier must performance specifications;
  - ++ AOs may maintain or adopt standards that are more stringent than those of Medicare;
  - ++ The AOs are required to notify Medicare of the accreditation decision of those suppliers billing Medicare
  - ++ Accreditation requirement does not apply to hospitals; and
  - ++ AO only needs to notify CMS for significant changes from what was approved on the AO's initial approved application.
- Including a requirement that a supplier must assist the beneficiary in obtaining his/her medical records if he/she requests.
- Including a requirement that the supplier must notify the AO of any subsequent changes to the modalities being offered since the accreditation decision was made.
- Clarifying that AOs must respond to complaints from any source with respect to an accredited supplier.
- Changing the regulations text to require that an AO notify CMS of any supplier deficiency putting Medicare beneficiaries in immediate jeopardy within 2 business days (previously 2 calendar days).
- Confirming that when a designated accrediting organization has its deeming authority withdrawn, CMS and the remaining AOs will work together in a collaborative effort to distribute suppliers affected by such withdrawal amongst other accreditations organizations within a reasonable time period.

7. Section 139: Improvements for Medicare Anesthesia Teaching Programs

Section 139 of the MIPPA establishes a special payment rule for teaching anesthesiologists and provides a directive to the Secretary regarding payments for the services of teaching certified registered nurse anesthetists (teaching CRNAs). It also specifies the periods when the teaching anesthesiologist must be present during the procedure in order to receive payment for the case at 100 percent of the fee schedule amount (the regular fee schedule rate). These provisions are effective for services furnished on or after January 1, 2010.

a. Teaching Anesthesiologists: Special Payment Rule

The criteria for the payment of teaching anesthesiology services and the special rule for the teaching anesthesiologist are similar to the current criteria for payment of teaching surgeon services and the payment rule for the teaching surgeon involved in overlapping resident cases. Thus, there is a similarity in the payment rules for these physician specialties who work closely together.

(1) Payment for Anesthesia Services Furnished by a Physician

Currently, if the physician, usually an anesthesiologist, is involved in furnishing anesthesia services to a patient, the services can be furnished under one of three different scenarios. The anesthesiologist may—

- Personally perform the anesthesia services alone;
- Be involved in the case as a teaching anesthesiologist with an anesthesia resident; or
- Provide medical direction of the performance of anesthesia services for two, three or four concurrent cases involving a qualified individual (who may be a CRNA, an anesthesiologist

assistant (AA), an anesthesia resident, or a student nurse anesthetist under certain circumstances).

Under the statute and CMS policy, if the anesthesiologist personally performs the anesthesia service alone or is involved in the case as a teaching anesthesiologist with an anesthesia resident, payment for the anesthesiologist's service is made at the regular fee schedule rate.

If the anesthesiologist furnishes medical direction for two, three, or four concurrent anesthesia procedures, then payment for the anesthesiologist's service is made, in accordance with section 1848(a)(4)(B) of the Act, at 50 percent of the otherwise applicable fee schedule amount.

(2) Methodology for Payment of Anesthesia Services

Payment for anesthesia services furnished by a physician is made under the PFS under section 1848(b)(2)(B) of the Act. The methodology for the calculation of the allowable amount is unique to anesthesia services only. Payment is made on the basis of anesthesia base units and time units, calculated from the actual anesthesia time of the case, instead of on the basis of work, PE, and malpractice RVUs. The base unit reflects all activities other than anesthesia time and includes usual preoperative and postoperative visits, the administration of fluids, and blood incident to anesthesia care and monitoring services. Payment for anesthesia services is also based on the anesthesia CF instead of the general PFS CF.

(3) Section 139(a) of the MIPPA

Section 139(a) of the MIPPA adds a new paragraph at section 1848(a)(6) of the Act to establish a ''special payment rule for teaching anesthesiologists''. This provision allows payment to be made at the regular fee schedule rate for the teaching anesthesiologist's involvement in the training of residents in either a single anesthesia case or in two concurrent anesthesia cases furnished on or after January 1, 2010.

(4) Discussion

The Accreditation Council on Graduate Medical Education (ACGME) is a branch of the AMA, and it accredits allopathic residency programs. In order for a hospital to receive Medicare graduate medical education payments for its training programs, the residents must be in an ''approved medical residency program'' Under § 413.75(b), an approved medical residency program is one approved by one of the national organizations listed in § 415.152. One of the national organizations is the ACGME.

ACGME's policies and procedures require that each accredited residency program comply with the institutional requirements and the specialty program requirements. For approved anesthesia residency programs, ACGME requirements for faculty supervision and training of anesthesia residents specify that a faculty member not direct anesthesia at more than two anesthetizing locations in the clinical setting. (See the ACGME Web site at *http://www.acgme.org.*)

Consistent with this requirement, the American Society of Anesthesiologists (ASA) has advised us that, when providing services in two concurrent cases, a teaching anesthesiologist might be engaged in two concurrent anesthesia resident cases, or in two mixed concurrent cases, one a resident case and the other a CRNA or AA case.

The statute applies the special payment rule for teaching anesthesiologists to the single resident case or two concurrent cases involving anesthesia residents as long as the teaching anesthesiologist meets the requirements in sections 1848(6)((A) and 1848(6)(B) of the Act. However, the statute does not directly address a single resident case that is concurrent to another case involving a CRNA, AA, or other qualified individual who can be medically directed. The issue is whether the medical direction payment rules apply to each of these cases or whether an alternative payment policy may apply.

As an alternative to applying the medical direction payment rules to the concurrent mixed cases, we proposed to apply the payment rule for teaching anesthesiologists to the resident case that is concurrent to another case which is paid under the medical direction payment rules. While this represents a broader interpretation, it still limits the applicability of the special payment rule for teaching anesthesiologists to resident cases consistent with the terms of section 139 of the MIPPA. (See 74 FR 33603 for a more detailed discussion of this option.)

Accordingly, we proposed to delete the current regulatory language at § 414.46(e) (which is no longer relevant) and add new language to specify that the special payment rule for teaching anesthesiologists applies to resident cases under the following scenarios:

- The teaching anesthesiologist is involved in one resident case (which is not concurrent to any other anesthesia case);
- The teaching anesthesiologist is involved in each of two concurrent resident cases (which are not concurrent to any other anesthesia case); or
- The teaching anesthesiologist is involved in one resident case that is concurrent to another case paid under medical direction payment rules.

Other than the application of the special payment rule for teaching anesthesiologists in the mixed concurrent case described above, we did not propose any other revisions to our medical direction payment policies.

Comment: Commenters supported our interpretation of section 139 of the MIPPA that allows the special payment rule for teaching anesthesiologist to apply if the teaching anesthesiologist is involved in one resident physician case that is concurrent to another case paid under the medical direction payment rules.

Response: We believe this interpretation is consistent with the statute and the ACGMS requirements that allow no more than two residents to be supervised concurrently. Our policy would allow the special teaching rule to apply in mixed concurrent cases, that is, the single resident case that is concurrent to another case not involving a resident that is paid under our medical direction payment rules. We are revising § 414.46 in this final rule with comment period as proposed.

Comment: Some commenters asked if there will be new claims service modifiers created for the teaching anesthesiologist or whether teaching anesthesiologists would continue to us the ''AA'' service modifier. They also asked if the ''GC'' modifier would continue to be used for physician supervision of resident cases.

Response: At this time, we are not creating a new claims service modifier for teaching anesthesiologists, but will inform teaching anesthesiologists to continue to use the ''AA'' modifier if they qualify as the teaching anesthesiologist under the three specific scenarios discussed above. The teaching anesthesiologist should also continue to use the ''GC'' certification modifier. (See Internet Only Manual (IOM) Medicare Claims Processing Manual Chapter 12, Section 50 K., titled Anesthesia Claims Modifiers. This can be found at www.cms.hhs.gov/manuals.)

b. Teaching Anesthesiologists: Criteria for Payment

(1) Criteria for Payment of Teaching Anesthesiologists

As part of the special payment rule established for teaching anesthesiologists, the statute requires that the teaching anesthesiologist is present during all key or critical

portions of the anesthesia procedure involved. In addition, the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure.

In the proposed rule, we discussed two options for implement this provision. One option would allow different teaching anesthesiologists in the same anesthesia group practice to be considered the ''teaching physician'' for purposes of being present at the key or critical portions of the anesthesia procedure. This option would permit a teaching anesthesiologist to handoff a key or critical portion of the anesthesia procedure to another teaching anesthesiologist as long as the other anesthesiologist is a member of the same group. Another option presented was to require that only one teaching anesthesiologist must be present during all of the key or critical portions of the procedure, which would effectively permit no handoffs. We proposed to more narrowly interpret the law and require that only one individual teaching anesthesiologist be present during all of the key or critical portions of the anesthesia procedure.

Anesthesiologists, including the ASA, have advised us that it may be common for different members of a teaching anesthesia group to provide the anesthesia service instead of a single teaching anesthesiologist. In the proposed rule, we solicited comments on how continuity of care and the quality of anesthesia care are preserved during handoffs, whether there is an accepted maximum number of handoffs, any industry studies that have examined this issue, what factors contribute to handoffs, and whether there are anesthesia practices that do not use handoffs. A handoff refers to any transfer of care for any period or a terminal transfer between two anesthesia providers during a single anesthesia case.

Comment: The ASA and many of its members stated the reasons for handoffs and their presumed benefits. In general, the commenters remarked that handoffs can improve the efficiency of operating rooms, permit teaching anesthesiologists to use their specialized skills to teach anesthesia residents in certain cases, prevent physician fatigue and error, and improve quality and patient safety.

Several medical organizations objected to our proposal and recommended that we implement the alternative proposal in the proposed rule to permit different anesthesiologists in the same anesthesia group practice to be considered the teaching anesthesiologist for purposes of being present at the key or critical periods of the anesthesia case.

Some commenters discussed handoffs in general and did not specifically tie their comments regarding handoffs to a key or critical period of the teaching anesthesia service.

Some commenters cited a 1982 study in the *Journal of Anesthesiology* (*56:456–461*), titled ''Critical Incidents Associated with Intraoperative Exchanges of Anesthesia Personnel''. This article examined anesthesia practices from four hospitals in Boston, two of which were teaching hospitals. The study examined 1,089 reports of preventable errors and failures associated with anesthesia management. In 28 incidents, the relief anesthesia provider in the handoff discovered an error or cause of an error. Although 70 of the 1089 were associated with substantive negative outcomes, none of these incidents were caused by a relieving anesthetist related to a handoff.

The study noted that ''there is a strong implication that relief is beneficial more often than not even aside from the presumed beneficial effect on the vigilance of the primary anesthetists.'' The study further noted that from the descriptions of the causes and discoveries of errors in these relief-related incidents, guidance can be drawn for the safe and effective conduct of the intraoperative exchange of anesthesia personnel. This article referred to substitutions for short breaks during long surgical procedures. It did not specify whether any of these substitutions took place during key or critical periods of the teaching case.

Based on its study of relief-associated events, the authors suggested the adoption of specific handoff protocols and communication processes to reduce errors. This protocol would address such factors as familiarity with the status of the patient, progress of the surgical procedure, trends in the anesthetic course, significant medical history, anesthesia plan, and arrangement of equipment, apparatus, drugs, and fluids. This is the only study on handoffs that commenters presented.

In its comments, the ASA described the ''SBAR'' protocol, or a variation of it, as the handoff procedure most widely taught and used in anesthesia practices, both academic and private. The SBAR protocol gives physicians a format to follow when initiating handoffs. SBAR is an acronym used to describe four basic requirements for transfer of patient care:

S = Situations: State what is going on with the patient, the type of procedure and when it started

B = Background: Explain clinical background leading up to the situation, including medical history, medications, allergies, anesthetic management (including drugs, fluids, and blood loss, etc.)

A = Assessment: Provide an assessment of the current state of the patient and describe what problems, if any, you think exist.

R = Recommendation: Recommend what you think needs to be done.

According to the ASA, some anesthesia departments have defined written protocols that they follow for handoffs, but many do not because the fundamentals of the handoff process are part of the skill set that is believed to be taught and practiced by all teaching anesthesiologists.

The ASA simply expressed the opinion that the appropriate timing of a handoff is a decision best left to the physicians responsible for the care of the patient. The ASA also stated that to raise the issue of quality in anesthesia handoffs where no issue or evidence exists exceeds CMS's authority in implementing section 139 of the MIPPA. The ASA is supportive of an approach where its members use their judgment to decide when to use handoffs and the necessary information exchanged. The ASA recommended that we implement the payment provision only and leave any issues involving handoffs unexamined.

Response: Despite the existence of the SBAR protocol, it is unclear to what extent teaching hospitals have now developed standardized tools, checklists, clinical practice guidelines, or other techniques to ensure the appropriate exchange of information, including the appropriate type and content of anesthesia information, and the assurance that optimum care occurs during handoffs.

We identified two abstracts to be presented to the ASA later this year that present limited information on handoffs. One study, ''Transfer of Anesthesia Care: Are We Hiding Bad Outcomes?'' by Vilma A. Joseph, M.D., M.P.H., Charles E. Kamen, B.A., Rhonda D. Levine, M.D., Alla Krayman, M.S., and Robert S. Lagasse, M.D. This study showed that of 1740 anesthesia cases without a transfer of care, there were 12 recorded adverse outcomes, while there were zero adverse outcomes in the 132 cases where there was a transfer of care. The other study is: ''Evaluating Safety of Handoffs between Anesthesia Care Providers'' by Rhonda Leopold, M.D., Stuart Hart, M.D., Heather Scuderi

Porter, B.A., and Neil Giovanni, M.D.''. This study pointed out that there are not many tools available for anesthesia care providers to ensure that the transfer of care occurs without error. In 70 completed surveys involving the transfer of care, 34 percent of anesthesia care providers found the current handoff process to be inadequate. The majority did believe that standardization of the process would improve patient care.

There appears to be a limited amount of research on handoffs, and a lack of a detailed, industry-defined process on their use. Commenters did not report widespread use of written protocols by academic facilities.

As noted previously, we think the teaching anesthesiologist payment policy in section 139 of the MIPPA and the handoff issues are separate, but related issues. The handoff issue is a quality of care issue not directly addressed in section 139 of the MIPPA. Therefore, we are implementing the payment provision of section 139 but not finalizing a formal policy on handoffs in this final rule. For future rulemaking, we may consider working with the industry to develop guidelines on handoffs. These guidelines may, among other things, address the content and type of information exchanged during handoffs and whether there should be any limitations on the number of handoffs permitted.

In response to comments, we believe it is appropriate to implement this payment provision consistent with current teaching anesthesia practices and handoff arrangements. Thus, different anesthesiologists in the same anesthesia group practice can be considered the teaching physician for purposes of the statutory requirement that the teaching anesthesiologist be present at the key or critical portions of the anesthesia service. Of course, the criteria for the presence of the teaching physician would also be met if only one teaching anesthesiologist was present during the key or critical periods of the anesthesia service.

We are revising § 415.178 to incorporate our policy that allows either a single teaching anesthesiologist or different teaching anesthesiologists in the same anesthesia group practice to be considered the teaching physician for purposes of being present at the key or critical portions of the anesthesia service.

c. Teaching CRNAs

(1) Payment for Anesthesia Services Furnished by a CRNA

Currently, a CRNA who provides anesthesia services while under the medical direction of an anesthesiologist is paid at 50 percent of the regular fee schedule rate as specified in section 1833(l)(4)(B)(iii) of the Act. A CRNA who provides anesthesia services without the medical direction of a physician is paid the regular fee schedule rate as specified in section 1833(l)(4)(A) of the Act.

(2) Payment for Anesthesia Services Furnished by a Teaching CRNA With a Student Nurse Anesthetist

The legislation that initially directed CMS to establish the CRNA fee schedule (that is, section 9320 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509)) did not address payment for services furnished by teaching CRNAs involved in the training of student nurse anesthetists.

In the preamble to the CRNA fee schedule final rule published in the July 31, 1992 **Federal Register** (57 FR 33888), we stated that we would pay the teaching CRNA who is not medically directed by a physician at the regular fee schedule rate for his or her involvement in a single case with a student nurse anesthetist as long as he or she was present with the student throughout the anesthesia case. No payment would be made if the teaching CRNA divided his or her time between two concurrent cases involving student nurse anesthetists.

In August 2002, based on the recommendations of the American Association of Nurse Anesthetists (AANA), we modified our policy to allow the teaching CRNA not medically directed by a physician to be paid a portion of the regular fee schedule rate for each of two concurrent cases involving student nurse anesthetists. If the teaching CRNA is present with the student nurse anesthetist during the pre- and post-anesthesia care for each of the cases involving student nurse anesthetists, the teaching CRNA can bill the full base units (comprised of pre- and post-anesthesia services not included in the anesthesia time units) for each case and the actual amount of anesthesia time per case. The resulting payment for each of these anesthesia cases is greater than 50 percent, but less than 100 percent, of the regular fee schedule amount because the full base units plus the actual anesthesia time units spent by the teaching CRNA in each of the two cases yields a payment that is greater than 50 percent of the regular fee schedule amount.

(3) Comparison of Payment Policies for Teaching CRNAs and Teaching Anesthesiologists

For several years, the ASA requested that we revise our payment regulations to allow the teaching anesthesiologist to be paid the regular fee schedule amount for each of two concurrent resident cases. In the CY 2004 PFS final rule with comment period (68 FR 63224), we finalized a policy to permit the teaching anesthesiologist to be paid similarly to a teaching CRNA for each of two concurrent resident cases. This policy took effect for services furnished on or after January 1, 2005.

Thus, the payment policy is the same for a teaching CRNA for each of two concurrent student nurse anesthetist cases, and for a teaching anesthesiologist for each of two concurrent resident cases. The policy is that the anesthesia provider is paid the full base units plus time units, based on the actual anesthesia time, relating to each of two concurrent cases.

(4) Payment Policy for an Anesthesiologist, or an Anesthesiologist and CRNA jointly, With a Student Nurse Anesthetist

Currently, there are circumstances where an anesthesiologist may be involved in the training of student nurse anesthetists in two concurrent anesthesia cases. These anesthesia cases are not paid under the teaching anesthesiologist payment policy, but are paid under the usual medical direction payment policy. Payment can be made for the physician's medical direction (that is, 50 percent of the regular fee schedule amount) for each of two concurrent cases.

If an anesthesiologist is medically directing two concurrent cases involving student nurse anesthetists and a CRNA is also jointly involved with the two student nurse anesthetist cases, then the physician service, in each case, can be paid under the medical direction rules at 50 percent of the regular fee schedule. Payment for the CRNA services would also be made at the medically directed rate (that is, 50 percent of the regular fee schedule) for CRNA services, but the time units used to compute the anesthesia fee would be based on the actual time the CRNA is involved in each case.

(5) Section 139(b) of the MIPPA

Section 139(b) of the MIPPA instructs the Secretary to make appropriate adjustments to Medicare teaching CRNA payment policy so that it—

• Is consistent with the adjustments made by the special payment rule for teaching anesthesiologists under section 139(a) of the MIPPA; and

• Maintains the existing payment differences between teaching anesthesiologists and teaching CRNAs.

We proposed to implement the first directive (under section 139(b)(1) of the MIPPA) by establishing a new payment policy for teaching CRNAs that is similar to the special payment rule for teaching anesthesiologists, and to limit applicability of the rule to teaching CRNAs who are not medically directed. We proposed to add a new regulation at § 414.61 to explain the conditions under which the special payment rule will apply and the method for calculating the amount of payment for anesthesia services furnished on or after January 1, 2010, by teaching CRNAs involved in the training of student nurse anesthetists. As proposed, we would pay the teaching CRNA at the regular fee schedule rate for each of two concurrent student nurse anesthetist cases. Our medical direction payment policy would continue to apply if both an anesthesiologist and a CRNA are involved in a student nurse anesthetist case that is concurrent to another medically directed anesthesia case.

We believe the second directive in section 139(b)(2) of the MIPPA will be satisfied as a result of these proposals. Section 139(b)(1) of the MIPPA instructs CMS to make appropriate adjustments to implement a payment policy for teaching CRNAs that is consistent with the special payment rule for teaching anesthesiologists. Section 139(b)(2) of the MIPPA instructs CMS to maintain the existing payment differences between teaching anesthesiologists and teaching CRNAs. There currently are no substantive differences in payment between teaching anesthesiologists and teaching CRNAs, and there would continue to be no such differences under our proposed policies.

Payment for Teaching CRNAs Involved in Anesthesia Cases With Student Nurse Anesthetists

Under current policy, when a CRNA is involved in a single student nurse anesthetist case, the teaching CRNA can be paid at the regular fee schedule rate if the teaching CRNA is present with the student for the pre- and post anesthesia services included in the base units and is continuously present during the anesthesia time of the case. We did not propose any change to this policy.

When the teaching CRNA is involved in two concurrent student nurse anesthetist cases, payment is based on the amount of anesthesia time the teaching CRNA spends with the student in each case. For example, as noted in the proposed rule, if the teaching CRNA spends 40 percent of his or her time in concurrent case #1 and 60 percent of his or her time in concurrent case #2, and the total anesthesia time in both cases is 3 hours (or 180 minutes), then we would currently pay as follows:

• *Case #1:* (Base units + (0.4 × 180/15)) × Anesthesia CF

• *Case #2:* (Base units + (0.6 × 180/15)) × Anesthesia CF

(The base units are explained earlier in section on general anesthesiology payment methodology.)

The current payment policy has been predicated on paying the teaching CRNA for his or her actual time spent in the student nurse anesthetist case. In the CY 2010 PFS proposed rule, we proposed to pay the teaching CRNA at the regular fee schedule rate for his or her involvement in two concurrent cases. To bill the base units for each concurrent case, the teaching CRNA must be present with the student nurse anesthetist during the pre and post anesthesia services included in the anesthesia base units.

If our goal is to minimize the effect of this change on teaching CRNAs' practice arrangements and time devoted to cases, then, as proposed, the teaching CRNA would continue to devote his or her time to the two concurrent anesthesia cases and not be involved in other services. The teaching CRNA would decide how to allocate his or her time to optimize patient care in the two cases based on the complexity of the anesthesia case, the experience and skills of the student nurse anesthetist, the patient's health status, and other factors.

We note that the Congress did not amend the statutory provisions relating to medical direction at section 1848(a)(4) of the Act. We do not believe the directives at section 139(b) of the MIPPA extend to other arrangements in which an anesthesiologist alone or both an anesthesiologist and CRNA together jointly supervise student nurse anesthetists during concurrent anesthesia cases. Therefore, we did not propose any changes to our current payment policies for anesthesia services furnished under other circumstances. We proposed that when an anesthesia provider (physician or CRNA) furnishes anesthesia services in concurrent cases under other circumstances, the current policies regarding medical direction will continue to apply.

The following is summary of the comments we received regarding section 139 of the MIPPA and teaching CRNAs.

Comment: Commenters supported the proposal to allow teaching CRNAs who are concurrently teaching two student nurse anesthetists to be able to bill the regular fee schedule rate for each anesthesia case involving the student nurse anesthetist. The commenters indicated this change is consistent with the adjustment made under section 139 of the MIPPA for teaching anesthesiologists involved in two concurrent resident cases.

Response: We are adopting our proposal that the teaching CRNA can be paid the full fee for his or her involvement in each of two concurrent cases involving student nurse anesthetists. While we are adopting this policy, we are concerned that it did not specifically address the availability of another anesthesia provider for the periods of concurrency for student nurse anesthetists. (In the case of teaching anesthesiologists and residents, section 139 specifically requires that the teaching anesthesiologist or another anesthesiologist with whom the teaching anesthesiologist has an arrangement is immediately available to furnish anesthesia services during the entire procedure.)

Subsequent to issuing the proposed rule and receiving comments, we learned more about the supervision requirements for student nurse anesthetists. According to the AANA, the standards of the Council on Accreditation of Nurse Anesthesia Programs address supervision of student nurse anesthetists in anesthesia cases. These standards require that in any case involving a student nurse anesthetist, including concurrent cases, a qualified anesthesia provider (CRNA or anesthesiologist) must be present and immediately available in the anesthetizing locations.

Furthermore, according to these standards, the qualified individual must be physically present in the area and immediately available for the student to summon for clinical assistance should it be required. As a result, if one teaching CRNA were temporarily occupied, another qualified anesthetist would respond.

Based on information received and in response to comments, we are requiring that the teaching CRNA be present during the case with the student nurse anesthetist. For periods of concurrency for two student nurse anesthetist cases, we are requiring that another anesthesia provider is available and can fulfill the requirements of the AANA standards.

Comment: Some commenters requested that we establish the same policy specified in section 139(a) of the MIPPA for teaching anesthesiologists

involved in two concurrent resident cases for situations where an anesthesiologist medically directs two concurrent student nurse anesthetists cases. The commenters stated that this would establish payment equity between teaching anesthesiologists and teaching CRNAs and not encourage anesthesiologists to select residents over student nurse anesthetists where the hospital has both types of anesthesia providers.

Response: We understand the commenters' concern and agree that their proposal would establish parity of payment in certain respects. However, in the proposed rule, we noted that the Congress did not amend the statutory provision relating to medical direction at section 1848(a)(4) of the Act. We do not believe the directives at section 139(b) of the MIPPA extend to arrangements in which anesthesiologists supervise two student nurse anesthetists during concurrent cases. While the anesthesiologist may engage in a teaching situation with a student nurse anesthetist, this does not constitute a teaching anesthesiologist relationship as conceived in the statute. The term ''teaching anesthesiologist'' as used in the Medicare statute refers to a teaching physician involved with a physician resident. Therefore, we will maintain our current policy that when an anesthesiologist is involved in two concurrent cases with student nurse anesthetists, the medical direction rules will apply.

Additionally, if we were to consider paying each student nurse anesthetist case at the regular fee schedule amount, it would be unclear what payment criteria would apply for the physician service. The teaching anesthesiologist criteria in section 139(a) of the MIPPA apply only to physician resident cases and not to student nurse anesthetist cases. It also does not seem appropriate to pay the regular fee schedule rate if the services fall within the terms of the statutory provision addressing medical direction under which the anesthesiologist is paid at 50 percent of the regular fee schedule rate. Therefore, we believe the most appropriate course is to maintain our current policy.

Comment: Commenters also requested that, in medical direction cases where there are two concurrent student nurse anesthetists directed by the anesthesiologist and one CRNA covering both student nurse anesthetist cases, that each medically directed CRNA service be paid at the usual medically directed rate or 50 percent of the anesthesia fee schedule.

Response: We make payment at 50 percent of the regular fee schedule amount for the physician who is medically directing the CRNA. We also make payment at 50 percent of the regular fee schedule amount for the service of the CRNA who is involved continuously with the patient in the administration of the anesthesia service. In the anesthesia scenario described in the comment, the student nurse anesthetist can be medically directed but payment cannot be made for the student nurse anesthetist service because he or she is not a qualified CRNA. If the CRNA is involved in two concurrent cases with the student nurse anesthetist, then we do not believe it would be reasonable to pay the usual medical direction fee for the CRNA service because the CRNA is not with the student throughout the case. We are finalizing the policy we proposed that the payment for the CRNA service would be made under the medical direction rules at 50 percent of the regular fee schedule amount, but that the time units used to compute the anesthesia fee would be based on the actual time the CRNA is involved in the case.

Comment: One commenter requested that CMS provide parallel rules for payment involving handoffs for all anesthesia providers, both teaching anesthesiologists and teaching CRNAs. Specifically, the commenter requested that CMS define anesthesia handoffs as the responsibility for care clearly transferred from one qualified anesthesia provider to the next; that handoffs are allowed for all portions of an anesthesia case; and that CRNAs be treated equitably as anesthesiologists.

Response: We addressed handoffs for teaching anesthesiologists in conjunction with our interpretation of the specific provision in section 139 of the MIPPA for coverage of teaching anesthesiologists with residents. We did not address handoff rules for teaching CRNAs. Because we made no proposal on this subject, we are not implementing the commenters' suggestion at this time.

Comment: A commenter requested that we establish a different payment modifier for teaching CRNAs to use for billing purposes when teaching student nurse anesthetists in single or concurrent cases. Currently, teaching CRNAs bill these services using the ''QZ'' modifier which is the same modifier they would use if they furnished the service alone. A new payment modifier would allow for differentiation in the claims processing system between the non-medically directed CRNA cases with student nurse anesthetists and those without the involvement of student nurse anesthetists.

Response: For the present, we will continue to use the existing claims modifier but will give consideration to whether a different modifier is needed to distinguish teaching CRNA cases from cases performed by a CRNA alone.

Comment: A commenter asked if the anesthesia teaching rules apply to an anesthesiologist assistant (AA). The services of AAs can be paid under the CRNA medical direction payment rules, but AAs must work under the supervision of an anesthesiologist.

Response: Our proposal applies only to teaching CRNAs who supervise student nurse anesthetists or to an anesthesiologist who provides medical direction for two concurrent cases involving student nurse anesthetists. It does not apply to AAs.

8. Section 144(a): Payment and Coverage Improvements for Patients with Chronic Obstructive Pulmonary Disease and Other Conditions—Cardiac Rehabilitation Services

Section 144(a) of the MIPPA amended Title XVIII of the Act, in pertinent part, to establish the benefit of cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) under Medicare Part B. The statute specifies certain conditions for these programs, with an effective date of January 1, 2010. The addition of the new CR and ICR programs is designed to improve the health care of Medicare beneficiaries with cardiovascular disease. This final rule with comment period implements these MIPPA provisions in order to ensure CR and ICR programs enhance the patient's clinical outcomes.

a. Background

Intensive cardiac rehabilitation (ICR) is a relatively new practice that is also commonly referred to as a ''lifestyle modification'' program. These programs typically involve the same elements as CR programs, but are furnished in highly structured environments in which sessions of the various components may be combined for longer periods of CR and may be more rigorous.

b. Cardiac Rehabilitation Coverage Under Medicare

One mechanism we use to establish coverage for certain items and services is the national coverage determination (NCD) process. An NCD is a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under Title XVIII.

Since 1982, Medicare has covered, under an NCD, cardiac rehabilitation for patients who experience stable angina, have had coronary artery bypass grafts, or have had an acute myocardial infarction within the past 12 months. The NCD is located in the Medicare NCD Manual (Pub. 100–03), section 20.10. Effective March 22, 2006, we modified the NCD language to cover comprehensive cardiac rehabilitation programs for patients who experience one of the following:

- A documented diagnosis of acute myocardial infarction within the preceding 12 months.
- A coronary bypass surgery.
- Stable angina pectoris.
- A heart valve repair/replacement.
- A percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting.
- A heart or heart-lung transplant.

Comprehensive programs must include a medical evaluation, a program to modify cardiac risk factors, prescribed exercise, education, and counseling and may last for up to 36 sessions over 18 weeks or no more than 72 sessions over 36 weeks if determined appropriate by the local Medicare contractors. Facilities furnishing cardiac rehabilitation must have immediately available necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment and be staffed with personnel necessary to conduct the program safely and effectively who are trained in advanced life support techniques and exercise therapy for coronary disease. The program must also be under the direct supervision of a physician. Until section 144(a) of the MIPPA is effective on January 1, 2010. ICR programs are covered under this NCD and are subject to the same coverage requirements.

c. Statutory Authority

Section 144(a) of the MIPPA amended the Medicare Part B program by adding new sections 1861(s)(2)(CC) and 1861(s)(2)(DD) of the Act to include items and services furnished under a new benefit referred to as a ''cardiac rehabilitation program'' and an ''intensive cardiac rehabilitation program,'' respectively. A cardiac rehabilitation program is defined in new section 1861(eee)(1) of the Act and an intensive cardiac rehabilitation program is defined in new section 1861(eee)(4)(A) of the Act.

A cardiac rehabilitation program is a physician-supervised program that furnishes the following: physician-prescribed exercise; cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment; outcomes assessment; and other items or services as determined by the Secretary under certain conditions. These items and services must be furnished in a physician's office, in a hospital on an outpatient basis, or in other settings as determined appropriate by the Secretary. A physician must be immediately available and accessible for medical consultation and emergencies at all times items and services are being furnished in a CR program except when provided in a hospital setting where such availability is presumed. The items and services furnished by a CR program are individualized and set forth in written treatment plans that describe the patient's individual diagnosis; the type, amount, frequency, and duration of items and services furnished under the plan; and the goals set for the individual under the plan. These written plans must be established, reviewed, and signed by a physician every 30 days.

An ICR program provides the same items and services under the same conditions as CR programs but must demonstrate, as shown in peer-reviewed published research, that they have accomplished one or more of the following: positively affected the progression of coronary heart disease, or reduced the need for coronary bypass surgery, or reduced the need for percutaneous coronary interventions (PCIs). The peer-reviewed published research must also show that the ICR program has resulted in a statistically significant reduction in 5 or more measures from their levels before ICR services to their levels after receipt of such services. These measures include low density lipoprotein; triglycerides; body mass index; systolic blood pressure; diastolic blood pressure; or the need for cholesterol, blood pressure, and diabetes medications. Beneficiaries eligible for ICR must have experienced the following: an acute myocardial infarction within the preceding 12 months; a coronary bypass surgery; current stable angina pectoris; a heart valve repair or replacement; a percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or a heart or heart-lung transplant. Section 1861(eee)(4)(C) of the Act, as added by section 144(a)(1)(B) of the MIPPA, states that an ICR program may be provided in a series of 72, 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks.

The statute authorizes the Secretary to establish standards for the physician supervising the ICR and/or CR programs to ensure that the physician has expertise in the management of individuals with cardiac pathophysiology and is licensed by the State in which the CR program (or ICR program) is offered. These standards ensure that the physician is responsible for the program and, in consultation with appropriate staff, is involved substantially in directing the progress of individuals in the program.

d. Provisions of the Proposed Regulation

We proposed to add § 410.49, ''Cardiac Rehabilitation Program and Intensive Cardiac Rehabilitation Program: Conditions of Coverage'' to our regulations.

Below is a summary of what we proposed for the new ICR and CR benefit in the proposed rule. (To read the proposed rule in its entirety, see the CY 2010 PFS proposed rule (74 FR 33606 through 33610, and 33675 through 33676.)

We proposed definitions with respect to the programs and services related to CR and ICR programs.

We listed the cardiac-related conditions for which CR and ICR items and services are eligible for coverage under this new benefit. We received several comments to add other conditions unrelated to cardiac conditions and will address those comments in section II.G.8.e. below.

We proposed that CR and ICR programs may only be provided in a physician's office or a hospital on an outpatient basis. Any additional settings will be added through future rulemaking.

We proposed that only a physician as defined in section 1861(r)(1) of the Act may establish the written individualized treatment plan, review the plan and update that plan. We received a few comments on this provision, specifically requesting that staff other than the physician should be able to update the plan. We address those comments in the section II.G.8.e. of this rule.

We proposed components of the CR and ICR program. All of the items and service related to the ICR and CR programs must be individualized to the beneficiary and delivered as part of the CR and ICR program. Any additional mandatory items and services will be added through future rulemaking.

We defined outcomes assessment as an evaluation of the patient's progress in the program using assessments from the commencement and conclusion of CR and ICR programs that are based upon patient centered outcomes. We also outlined the timing of when the patient centered outcomes must be measured—at the beginning of the CR and ICR program, prior to each 30-day review of

the individualized treatment plan, and at the end of the CR and ICR program.

Based on the outcomes assessment, the beneficiaries' plan of care should be updated as needed to ensure that the beneficiary continues to receive appropriate items and services based on his or her clinical needs.

We proposed the number of sessions that may be provided to a beneficiary participating in a CR program. The number of sessions that may be provided as part of an ICR program were specifically set forth in the statute and were included in the proposed rule as well.

We requested comments for specific physician standards that should be required to ensure that the physician is qualified to supervise the CR and ICR program. In addition to requesting comments for physician standards, we discussed two physician roles in the CR and ICR programs.

- Medical director: The physician who oversees or supervises the CR and ICR program at each site and who has expertise in the management of patients with cardiac pathophysiology. This person must be involved substantially in directing the progress of individuals in the program.
- Supervising physician: A physician that is immediately available and accessible for medical consultations and medical emergencies at all times items and services are being furnished under the CR and ICR program. This physician must also have expertise in the management of individuals with cardiac pathophysiolgy.

We have added definitions for the medical director and supervising physician to the regulations text and discuss these additions in section II.G.8.f. of this final rule with comment period.

We noted in the proposed rule that physician supervision of the program is limited to a physician who is the program medical director or a program staff physician serving as the supervising physician. This person must be a physician as defined in section 1861(r)(1) of the Act and not another CR or ICR staff member.

We proposed that the statutorily-required ongoing physician availability for medical consultations and medical emergencies would be met through existing definitions for direct physician supervision in physicians' offices and hospital outpatient departments at § 410.26(a)(2) (defined through cross references to § 410.32(b)(3)(ii)) and § 410.27(f), respectively. We stated that direct supervision, as defined in the regulations, is consistent with the language of the MIPPA because the physician must be present and immediately available where the services are being furnished. The physician must also be able to furnish assistance and direction throughout the performance of the services, which would include medical consultations and medical emergencies.

For CR and ICR services provided in physicians' offices and other Part B settings paid under the PFS, we proposed that the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service or procedure in accordance with the § 410.26(b)(5) as described in § 410.26(a)(2) of this subpart (defined through cross references to § 410.32(b)(3)(ii) of this subpart). This does not mean that the physician must be in the room when the service or procedure is performed.

For CR and ICR services provided to hospital outpatients, direct physician supervision is the standard set forth in the April 7, 2000 OPPS final rule with comment period (68 FR 18524 through 18526) for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. We stated that we currently define and specify the requirement for direct supervision for services furnished in provider-based departments of hospitals at § 410.27(f). For this purpose, the physician must be on the premises of the location (meaning the provider-based department) and immediately available to furnish assistance and direction throughout the performance of the procedure. This does not mean that the physician must be present in the room when the procedure is furnished. We also noted that if we were to propose future changes to the physician office or hospital outpatient policies for direct physician supervision, we would provide our assessment of the implications of those proposals for the supervision of cardiac rehabilitation services at that time. We note that in the CY 2010 OPPS/ASC proposed rule (74 FR 35362 through 35370), we proposed changes to the policy for direct physician supervision of hospital outpatient therapeutic services. We have addressed the application of the proposed and final hospital outpatient physician supervision policies in section II.G.8.e. below.

The MIPPA provisions state that in the case of items and services furnished under such a program in a hospital, physician availability shall be presumed. As we have stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68702 through 68704), the longstanding presumption relating to direct physician supervision for hospital outpatient services means that direct physician supervision is the standard for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals, and we expect that hospitals are providing services in accordance with this standard.

We received the majority of the comments on the above supervising physician provision and have addressed those in section II.G.8.e. of this final rule.

In our proposal, we noted that the program medical director may fulfill both roles of medical director and supervising physician (of individual CR and ICR services furnished to patients) provided that the requirements for direct physician supervision as required in § 410.26 and § 410.27 are met when CR or ICR items and services are furnished, as discussed above.

In addition to the CR requirements, section 1861(eee)(4) of the Act requires ICR programs to meet several additional standards. To become qualified, an ICR program must demonstrate through peer-reviewed, published research that it has accomplished one or more of the following: (1) Positively affected the progression of coronary heart disease; (2) reduced the need for coronary bypass surgery; or (3) reduced the need for percutaneous coronary interventions (PCIs). A qualified ICR program must also demonstrate through peer-reviewed published research that the ICR program accomplished a statistically significant reduction for patients in 5 or more specific measures from the individual's levels before ICR services to their levels after receipt of such services. These measures include: (1) Low density lipoproteins; (2) triglycerides; (3) body mass index; (4) systolic blood pressure; (5) diastolic blood pressure; and (6) the need for cholesterol, blood pressure, and diabetes medications. To ensure that ICR programs meet these standards, we proposed that ICR programs apply to CMS to receive approval as a qualified ICR programs. Only approved programs would be eligible for Medicare coverage and would be required to undergo regular re-evaluation to maintain such status. We did not propose any specific approval process(es), but requested comments on what process should be adopted by CMS. No comments were received advocating for any specific process(es), but we did receive comments requesting that any process adopted must allow public input and be open and transparent. We have

addressed these comments and the ICR approval process in section II.G.8.e. of this final rule.

e. Analysis of and Response to Public Comments

We received over 100 public comments. Many were supportive of our proposals to establish CR and ICR rules. Most comments also addressed several of the proposed provisions in the rule. The following is a summary of the issues and our responses.

Comment: Regarding the application of the direct physician supervision requirement to hospital outpatient services, many commenters noted that the CY 2010 PFS proposed rule cited references to the current regulations in § 410.27(f), while the CY 2010 OPPS/ASC proposed rule proposed several new policies for the direct supervision of hospital outpatient therapeutic services. The commenters requested that CMS clarify that for hospital outpatient services, the proposed definitions and policies would apply.

Response: We understand the commenters' concerns and requests for clarification and have attempted to clarify the direct physician supervision requirement below. The proposed general policies for the direct supervision of hospital outpatient therapeutic services would apply to CR and ICR services furnished to hospital outpatients, with the exception of the required credentials of the supervising practitioner, as specifically discussed in the CY 2010 OPPS/ASC proposed rule for CR and ICR services. Consistent with section 1861(eee)(2)(B) of the Act, a physician must be the supervising practitioner for CR and ICR services in a hospital setting. The final policies for payment and direct physician supervision of CR and ICR services furnished to hospital outpatients are discussed in detail in section XII.B.3. through 4. of the CY 2010 OPPS/ASC final rule with comment period.

Comment: Several commenters requested that CMS allow NPPs to satisfy the physician supervision requirements for CR and ICR services. The commenters stated that the proposal in the CY 2010 OPPS/ASC proposed rule would allow certain NPPs (nurse practitioners, physician assistants, clinical nurse specialists and certified nurse-midwives) to provide direct supervision of services which they may perform themselves within their State scope of practice and hospital-granted privileges and following all other requirements. The commenters concluded that CMS should not exclude CR and ICR services from this new policy.

Response: We understand the commenters' concern regarding allowing NPPs to satisfy the physician supervision requirement. We cannot adopt this request because the statutory language of the MIPPA defines both cardiac rehabilitation and intensive cardiac rehabilitation as ''physician-supervised'' programs. A physician is defined in section 1861(r)(1) of the Act. The MIPPA also specifically requires that ''a physician is immediately available and accessible for medical consultation and medical emergencies at all times items and services are being furnished under the program * * *;'' The text of the statute uses the word ''physician'' and does not include NPPs. We believe, based on the statutory language in MIPPA and the statutory definition of physician, that the statute does not provide us the flexibility to allow the supervising role to be filled by a non-physician practitioner. In other words, for the purposes of the CR and ICR programs, whether furnished in a physician's office, hospital outpatient setting or other Part B setting, the direct physician supervision definition applies only to a physician as defined in section 1861(r)(1) of the Act.

Comment: Several commenters requested that CMS remove the requirement from § 410.49(f) for patients to participate in a minimum of 2 CR sessions per week. The comments noted that such a requirement is not supported by specific published evidence and that many patients benefit from fewer than 2 sessions of CR per week. In addition, patients who have difficulty attending CR (due to long traveling distance, limited access to transportation, etc.) may not be able to attend 2 sessions per week and should not be prohibited from participating in CR because of transportation barriers.

Response: We understand and agree with these concerns and have removed from § 410.49(f) the requirement for patients to participate in a minimum of 2 CR sessions per week, as improved outcomes have been demonstrated in patients who participate in fewer than 2 CR sessions each week.

Comment: Many commenters also recommended that CMS revise the time period over which patients are eligible for CR services. The commenters suggested that we allow coverage for CR services for up to 36 sessions over 36 weeks. Additional commenters requested that we remove a provision that enabled Medicare contractors to extend coverage to up to 72 sessions.

Response: We agree with the comments requesting coverage for 36 sessions over 36 weeks. We have removed the requirement for CR patients to participate in a minimum of 2 CR sessions each week, and we have revised proposed § 410.49(f) to allow up to 36 sessions over 36 weeks. While the proposal to cover up to 36 CR sessions over up to 18 weeks was reasonable and consistent with the NCD, we agree that improved outcomes have been demonstrated in patients who participate in as little as one CR session per week.

We disagree with the suggestion that we remove contractor discretion under section 1862(a)(1)(A) of the Act to approve additional sessions of CR. As noted in the background, the statute required that CR programs be highly individualized and structured to meet an individual's needs. The programs are directed by physicians with expertise in cardiac pathophysiology. Our experience has been that not all patients require, and not all supervising physicians support, additional sessions for all beneficiaries. While some patients may continue to benefit from additional sessions, we believe that beneficiaries and the Medicare program will be best served if the 36 additional CR sessions are approved by local Medicare contractors based on each individual patient's specific circumstances. Therefore, we have changed the final rule to allow coverage of up to 36 CR sessions for up to 36 weeks and with the option for Medicare contractors to approve an additional 36 sessions over an extended period of time. The amount of additional time is determined by the Medicare contractor.

Comment: Various commenters requested that we use the term ''comprehensive cardiac rehabilitation'' rather than ''general cardiac rehabilitation'' when referring to CR programs (as opposed to ICR programs). Other commenters request that CMS not use the term ''intensive cardiac rehabilitation'' when referring to lifestyle modification programs as such a term implies that these programs are more effective than CR programs.

Response: We understand the confusion regarding the terminology used to describe CR and ICR, but do not agree with the public comments recommending that we use different terminology. We used the adjective ''general'' for ''cardiac rehabilitation'' in the preamble and some sections of the proposed rule to try to distinguish CR programs from ICR programs for the benefit of the reader. We accept the commenter's premise that a different adjective could have been used for that purpose. In the final regulation text in § 410.49(a), we removed the adjective ''general.'' We are not adopting the recommendation to change the adjective

to ''comprehensive'' cardiac rehabilitation. We believe that term may be even more confusing given the existence of the separate ''intensive cardiac rehabilitation'' definition in § 410.49(a). In order to avoid any confusion caused by an adjective, we will describe the benefit in section 1861(eee)(1) of the Act as ''cardiac rehabilitation.'' We will amend the regulation in § 410.49(f) to eliminate the adjective ''general.'' We disagree with commenters that suggested that the term ''intensive cardiac rehabilitation'' should not be used. Intensive cardiac rehabilitation was the term specifically used in the MIPPA and added in section 1861(eee)(4) of the Act. In addition to the regulatory text changes, the preamble of the final rule refers to ''cardiac rehabilitation'' and ''intensive cardiac rehabilitation.''

Comment: Some commenters expressed confusion or suggested the need for clarification regarding the process by which ICR programs become approved by CMS and how individual sites wishing to furnish ICR items and services are able to participate. Other commenters disagreed with our proposal. Some commenters stated that establishing a process for ICR program approval should include stakeholder involvement and should not result in significant administrative costs. These commenters also insisted that the process be clear and concise so that all stakeholders know how to become approved as an ICR program or site.

Response: We agree with many of the points offered by the commenters and are clarifying the process for the approval of ICR programs and the specific sites furnishing these new part B services. Based on the comments we received, we are using the NCD process to determine whether an ICR program meets the statutory requirements set forth in section 1861(eee)(4) of the Act. The NCD process, as authorized by section 1862(l) of the Act, is open, transparent, and provides an opportunity for public comments on a proposed national coverage determination (NCD). The NCD process is a well known process; therefore, stakeholders know what to expect when we open an NCD to review an ICR program. In addition to using the NCD process to determine whether ICR programs fall within the scope of the new Part B benefit, this final rule with comment period clarifies the distinct roles of an ICR approved program and the individual sites that would provide the ICR items and services. An ICR program is a physician-supervised program that furnishes cardiac rehabilitation and has shown, in peer-reviewed published research, that it improves patients' cardiovascular disease through specific outcome measurements. By statute, an ICR program must demonstrate by peer-reviewed published research that the program satisfies specific metrics. We typically consider and review peer-reviewed published literature through the NCD process. An ICR site, on the other hand, is a hospital outpatient setting or physician's office that is providing intensive cardiac rehabilitation utilizing an approved ICR program. For purposes of appealing an adverse determination, an ICR site is considered a supplier (or prospective supplier) as defined in § 498.2.

In this final rule with comment period, we are requiring that all ICR programs be approved through the NCD process. The NCD process will review each ICR program based on peer-reviewed published research, to ensure the program (or programs) under evaluation demonstrates that it satisfies the specific standards set forth in section 1861(eee)(4) of the Act. This process will involve at least one 30-day public comment period at which time the public may comment on the proposed decision. We believe this process allows for significant stakeholder involvement and is open and transparent, consistent with the commenters' request. Once we have approved an ICR program or programs through the NCD process, individual sites wishing to furnish ICR items and services via an approved ICR program may enroll with their local Medicare contractor to become an ICR program supplier as outlined in § 424.510.

We note that this enrollment process will ensure that specific sites meet the remaining statutory and regulatory requirements needed to furnish ICR services and provide a mechanism to appeal an adverse determination. With regards to billing and payment of CR and ICR services, physician office suppliers and hospital providers will continue to use their CMS Certification Number (supplier or provider number) and appeals related to the payment of claims will follow those separate processes.

Comment: Several commenters expressed opposition to the proposed requirement for all ICR programs to request and receive approval as a CMS approved ICR program based on peer-reviewed published research demonstrating that the program accomplishes specific outcomes.

Response: We do not agree with public commenters who oppose the provision requiring approval of all ICR programs. We believe that the statute requires ICR programs to be evaluated based on peer reviewed published research. The only way we are able to ensure that ICR programs are demonstrating these outcomes and that ICR sites are eligible for payment as required by the MIPPA is by reviewing the program using peer reviewed published research. We agree that the process adopted by CMS to review ICR programs must include public input and the NCD process will provide an opportunity for public participation. The NCD process may be internally generated by CMS or requested by an external party. ICR programs evaluated through an internally generated NCD are not required to submit peer-reviewed published research, as CMS identifies relevant research during the evidence review process. ICR programs that submit an NCD request, should submit the peer-reviewed published research upon which they are requesting approval. Specific information on the NCD process is available in the **Federal Register** notice (68 FR 55634).

Once ICR programs are approved through the NCD process, individual sites wishing to furnish ICR services must enroll with their local Medicare contractors. The ICR sites will be required to demonstrate that they meet the remaining regulatory and statutory requirements relating to state licensure, expertise in the management of individuals with cardiac pathophysiology, cardiopulmonary training, and certification in basic life support and advanced cardiac life support. By requiring enrollment via a local Medicare contractor as a supplier, a prospective ICR site would be entitled to appeal rights as outlined in 42 CFR part 498 if a site is not approved as meeting those standards. As noted above, this enrollment does not affect reporting and payment of CR and ICR services furnished by the hospital provider in the hospital outpatient setting. A hospital's enrollment as an ICR site ensures a separate appeal right related to the ICR site approval.

Comment: Several commenters recommended that we remove the requirement for ICR programs seeking approval to submit peer-reviewed published research in order to achieve approval. The commenters stated that most sites where ICR services are furnished do not publish their own data and should not have to collect voluminous data in order to become approved if the program is modeled after another program for which research has been published.

Response: We agree that individual sites furnishing ICR services are not required to submit data specific to the

site. It was not our intent to require each site where ICR items and services were being furnished to submit peer-reviewed published research specific to their site. Rather we intended, and have further clarified in this final rule with comment, that we will evaluate peer-reviewed published research to approve ICR programs through the NCD process. The peer-reviewed published research required for CMS approval as an ICR program is not a requirement of the individual ICR sites. Peer-reviewed published research submission is only a requirement of the ICR programs being reviewed for CMS approval via the NCD process. We are amending § 410.49(c)(3) to eliminate the need for reporting site specific outcome data.

Comment: Several commenters requested that we include additional indications for coverage of CR and ICR services. One commenter requested coverage for patients diagnosed with diabetes, breast cancer, prostate cancer, and metabolic syndrome. Another commenter requested coverage for patients with heart failure, peripheral artery disease, type 2 diabetes, high blood pressure, metabolic syndrome, post breast cancer treatment, and watchful waiting for prostate cancer.

Response: We do not agree that CR and ICR services should be covered for these non-cardiac patient populations. Extending ICR to other illnesses would appear to require additional legislation. We do not agree, based on currently available evidence, that coverage of CR should be expanded to include heart failure patients. If we determine based on supportive evidence that coverage for CR should be expanded to additional cardiac patient populations, such a decision will be made through an NCD.

Comment: Numerous commenters requested that CMS completely remove the requirement for the CR medical director to ''review and sign the plan prior to initiation of CR'' for all CR patients. The commenters state that such a requirement requires the medical director to review each patient's medical record to determine if the referring physician's treatment plan is appropriate and such a review is ''completely unrealistic, unnecessary, potentially costly and could prevent patients from receiving their therapy in a timely manner.''

Response: We do not agree with the public comments requesting that we remove the requirement for a physician to review and sign patients' treatment plans. We have clarified at § 410.49(b)(2)(v) that the treatment plan must be signed by a physician. We also note the importance of ensuring that the medical director and all CR and ICR staff are familiar with the treatment plan and any changes to the treatment plan. While the medical director is not required to scrutinize each patient's medical record, he or she should be aware of the patient's conditions and progress through the program. As the medical director is responsible for the program as a whole, he or she should at least be knowledgeable of each patient's progress through CR or ICR.

Comment: Several commenters requested that we establish clear, concise practice guidelines for practitioners to follow. We received numerous comments addressing qualifications for CR and ICR program medical directors, supervising physicians and support staff. Many commenters referred to the American Heart Association (AHA)/American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) description of medical director duties and levels of expertise as preferred guidelines and other comments stressed the importance of administration and management experience for the medical director. Guidelines released by the AHA/AACVPR were also cited with respect to standards for supervising physician(s) and support staff. Commenters suggested that CR and ICR staff be certified in Basic Life support (BLS) and meet performance measures identified by the AACVPR. Other commenters recommended that all staff maintain current cardiopulmonary resuscitation (CPR) certification and advanced cardiac life support (ACLS) certification and automated external defibrillator (AED) training. Commenters also requested that CMS stress the importance of incorporating a multidisciplinary staff in CR and ICR programs.

Response: We understand the commenters' requests and recommendations. In the proposed rule, we solicited comments on whether we should adopt practice guidelines and if so what guidelines should be adopted. We did not receive any comments on specific guidelines CMS should adopt besides the AHA/AACVPR guidelines discussed in the preamble of the proposed rule. While those guidelines are encouraged for CR and ICR programs and sites, we are not mandating that those guidelines be used in this final rule with comment period. Instead we have required in § 410.49(d) and (e) that in addition to the statutory required qualifications, the medical director and supervising physician(s) must have cardiopulmonary training in basic life support or advanced cardiac life support.

Comment: Commenters requested that we recognize registered dietitians and occupational therapists as part of the CR and ICR multidisciplinary team.

Response: We agree that these professionals may be part of the multidisciplinary team working with CR and ICR patients during CR and ICR sessions. While they may comprise part of the CR and ICR support staff, they may not supervise sessions or bill separately for services furnished during CR or ICR sessions. For more information on payment issues, see section II.G.8.g. of this final rule with comment period.

Comment: Some commenters requested that we remove the requirement for CR and ICR patients to participate in aerobic exercise during every CR or ICR session.

Response: We understand these commenters' concerns but believe these commenters misunderstood the aerobic exercise requirement. In the proposed rule, (§ 410.49(b)(2)(i)), we proposed to require patients to participate in aerobic exercise each day CR and ICR services are furnished. If patients participate in more than one CR or ICR session in a single day, then they are required to exercise aerobically in one, but not every, session.

Comment: Several commenters requested that we revise the language addressing outcomes assessments to recognize that some patient-centered outcomes will not demonstrate measurable changes within a 30-day period and should not be measured as frequently as every 30 days.

Response: We agree with these commenters that certain outcomes measures may not change significantly in a 30-day period and will allow CR and ICR programs flexibility with respect to what outcomes must be measured every 30 days. Measurement of outcomes that typically exhibit no or minute changes during a 30-day period is not required.

f. Provisions of the Final Regulation

This final rule maintains and refines coverage for CR for beneficiaries with the six conditions as originally established in Pub. 100–03, section 20.10 as this coverage was determined to be reasonable and necessary under section 1862(a)(1)(A) of the Act due to a high level of supporting clinical evidence. We may use the NCD process in the future if necessary to identify additional medical indications for cardiac patients who could obtain CR under Medicare Part B.

In § 410.49(a), we provide definitions of key terms used in this section. Most of the key terms received no comments

and our final rules are identical to the proposed definition terms for: (1) Cardiac rehabilitation; (2) individualized treatment plan; (3) outcomes assessment; (4) physician; (5) physician-prescribed exercise; and (6) psychosocial assessment. We have changed the term intensive cardiac rehabilitation to intensive cardiac rehabilitation program, but maintained the original definition, in order to delineate between ICR programs and ICR program sites in § 410.49(a).

We have added the following terms and definitions to § 410.49(a):

- Intensive cardiac rehabilitation program site which means a hospital outpatient setting or physician's office that is providing intensive cardiac rehabilitation utilizing an approved ICR program.
- Medical director which means a physician that oversees or supervises the cardiac rehabilitation or intensive cardiac rehabilitation program at a particular site.
- Supervising physician which means a physician that is immediately available and accessible for medical consultations and medical emergencies at all times items and services are being furnished to individuals under cardiac rehabilitation and intensive cardiac rehabilitation programs.

In § 410.49(b), we set forth the general rules for covered beneficiary rehabilitation services and describe the required components of the program. The covered patient populations remain unchanged and include beneficiaries who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months.
- A coronary artery bypass surgery.
- Current stable angina pectoris.
- Heart valve repair or replacement.
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting.
- A heart or heart-lung transplant.

We are changing the final indication to include ''cardiac'' when discussing other conditions that may be considered for coverage. The final indication states, for cardiac rehabilitation only, other cardiac conditions as specified through a national coverage determination.

The required components of cardiac rehabilitation programs remain unchanged, but we have clarified that the individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

In § 410.49(c), we establish the specific standards that ICR programs must meet. We have clarified how an ICR program will be evaluated through the NCD process, and how specific ICR sites will be evaluated to ensure those entities meet the regulatory requirements.

In order to utilize a clear and transparent process for approving ICR programs, the programs will be evaluated through the NCD process to determine if each program demonstrates through peer-reviewed published research that it has accomplished one or more of the following for its patients:

- Positively affected the progression of coronary heart disease.
- Reduced the need for coronary bypass surgery.
- Reduced the need for percutaneous coronary interventions.

ICR programs must also demonstrate through peer-reviewed published research a statistically significant reduction in 5 or more of the following measures for patients from their levels before CR services to after CR services:

- Low density lipoprotein.
- Triglycerides.
- Body mass index.
- Systolic blood pressure.
- Diastolic blood pressure.
- The need for cholesterol, blood pressure, and diabetes medications.

Individual sites wishing to furnish ICR items and services through an approved ICR program must enroll with their local Medicare contractor as an ICR program site. An ICR site will be considered a supplier or putative supplier for purposes of the appeals process in 42 CFR part 498 related to the approval of the ICR site.

In § 410.49(d), we list the specific standards that physicians must meet to be a medical director or supervising physician. All medical directors and supervising physicians must possess all of the following:

- Expertise in the management of individuals with cardiac pathophysiology.
- Cardiopulmonary training in basic life support or advanced cardiac life support.
- Be licensed to practice medicine in the State in which the cardiac rehabilitation program is offered.

In § 410.49(f), we list the specific limitations for the number of and time period over which CR and ICR sessions may be provided. The limitations for ICR coverage remain unchanged and allow for coverage of up to 72, 1-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks. We have changed the limitations for CR coverage to allow a maximum of 2, 1-hour sessions per day for up to 36 sessions over up to 36 weeks with the option for an additional 36 sessions over an extended period of time if approved by the Medicare contractor under 1862(a)(1)(A) of the Act.

In addition to the provisions above, we have made the following revisions in the final rule:

- To clarify that the proposed and final policies for the direct supervision of hospital outpatient therapeutic services, as discussed in the CY 2010 OPPS/ASC final rule with comment period, do apply to CR and ICR services furnished to hospital outpatients. Due to specific language in the MIPPA pertaining to a physician being immediately available and accessible for medical consultation and medical emergencies at all times items and services are being furnished under the program, a physician as defined in section 1861(r)(1) of the Act must supervise CR and ICR sessions, whether furnished in physicians' offices, hospital outpatient settings, or other Part B settings.
- To remove the term ''general cardiac rehabilitation'' and replace with ''cardiac rehabilitation.''
- To clarify CR and ICR medical director and supervising physician standards.
- To clarify that CR and ICR patients must exercise aerobically each day CR and/or ICR services are furnished and are not required to exercise aerobically during every CR or ICR session. If more than one session is furnished during 1 day, then patients are required to exercise aerobically during only one of the sessions.
- To allow flexibility in the 30-day patient centered outcomes measurements in order to allow outcomes that may not exhibit changes during a 30-day period of time to be measured less frequently, but no fewer times than at the beginning and end of patients' participation in a CR or ICR program.

g. Coding and Payment

(1) Cardiac Rehabilitation (CR) Payment

Currently, the following CPT codes are used for CR services described in section 144(a) of the MIPPA: CPT code 93797, *Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session*) and CPT code 93798, *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session).* We did not propose to revise these codes under the PFS because the CR program authorized by the existing National Coverage Determination (NCD) is essentially the same as what is included in the MIPPA.

(2) Intensive Cardiac Rehabilitation Payment

The statute requires that the hospital Outpatient Prospective Payment System

(OPPS) payment amount for CR services be substituted for ICR under the PFS, specifically the payment for CPT codes 93797 and 93798 or any succeeding HCPCS codes for CR. We proposed to create two new HCPCS codes for ICR services. These codes may only be billed by ICR programs that have been approved by CMS. The proposed codes are as follows:

- GXX28, *Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session.*
- GXX29, *Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session.*

These HCPCS codes will be recognized under the PFS and the OPPS. Under the OPPS, the existing CR HCPCS codes, CPT codes 93797 and 93798, are assigned to APC 0095 (Cardiac Rehabilitation) for CY 2009. Because the payment under the PFS for the two proposed ICR G-codes is required to be the same as the payment for CR services under OPPS, we proposed to pay the same amount as will be established through rulemaking for CY 2010 OPPS. We proposed that this amount will be adjusted for the appropriate locality by applying the GPCI under the PFS. The CY 2010 proposed APC assignments and payment rates for these two ICR G-codes were published in the CY 2010 OPPS/ASC proposed rule (74 FR 35361).

We note that when a CR/ICR service is furnished in a hospital outpatient department, a physician cannot bill the Medicare contractor for CR/ICR unless the physician personally performs the CR/ICR service. To personally perform the CR/ICR service, the physician would provide direct care to a single patient for the entire session of CR/ICR that is being reported. In this case, the hospital would report the CR/ICR service and be paid the OPPS payment amount for the facility services associated with the CR/ICR session and the physician would report and be paid the PFS amount for the CR/ICR service. A physician cannot bill under the PFS for CR/ICR services furnished in a hospital for which the physician furnishes only supervision or for services furnished in part by others. If the physician furnishes no direct CR/ICR services for a given session on a given day or provides direct CR/ICR services for less than the full session, then only the hospital would report the CR/ICR services and these services would be paid only under the OPPS.

The following is a summary of the comments we received regarding the payment of CR services under section 144(a) of the MIPPA.

Note: We received comments concerning the role of physical therapists, and occupational therapists in providing CR, ICR, and pulmonary rehabilitation (PR). Those comments are addressed in the PR section which follows this section.

Comment: One commenter stated that the physician work and staff resources required to perform the mandatory outcomes assessment are not valued in the physician work and PE RVUs established for CPT codes 93797 and 93798. The commenter recommends separate reporting and payment for the outcomes assessment.

Response: We note that an outcomes assessment is part of the CR benefit established by the Congress. While it may not have been described specifically in the CR program authorized by the existing NCD we believe an assessment of the patient's condition before initiating treatment and at periodic intervals to measure the patient's progress would be an expected part of treatment. In addition we note that the language at § 410.49 has been revised to allow more flexibility with regard to the outcomes that must be measured every 30 days. Section 410.49 requires that patient centered outcomes measurements must be taken no fewer times than at the beginning and end of a patient's participation in a CR or ICR program.

Comment: Some commenters requested an increase in the payment for traditional CR. One commenter also stated concerns about the way payment for ICR was established.

Response: The MIPPA made no substantive changes to the CR program authorized by the existing NCD and reported using CPT codes 93797 and 93798. Therefore, we proposed no changes to payment for these codes under the PFS. Under the statute, the payment for ICR under the PFS is based on the OPPS payment amount for CR services. Please see section XII.B.3 of the CY 2010 OPPS/ASC final rule for a discussion of how the payment amounts for CR and ICR were established under the OPPS.

Payment for CR

After consideration of the public comments we received, we are finalizing our CY 2010 proposal, without modification, to pay for CR using CPT codes 93797 and 93798.

Payment for ICR

We also are also finalizing our CY 2010 proposal to adopt the new 2010 PFS HCPCS G-codes for ICR with the following descriptors:

- G0422, *Intensive cardiac rehabilitation; with or without continuous ECG monitoring, with exercise, per hour, per session);* and
- G0423, *Intensive cardiac rehabilitation; with or without continuous ECG monitoring, without exercise, per hour, per session.*

As required by statute, payment under PFS for these services will be based on the OPPS payment amount for CR services. For more information on how the OPPS payment amount for ICR was established, see section XII.B.3 of the CY 2010 OPPS/ASC final rule. We have added the phrase ''per hour'' to the descriptors of these codes because we believe that CR services generally last one hour as documented by existing claims data for CR services. Section 1861(eee)(4)(C) of the Act provides for up to 72, 1-hour sessions of ICR and hence, adding ''per hour'' to the two new HCPCS code descriptors for ICR services implements the statutory definition of an ICR session as being 1 hour of service.

Moreover, we have established the payment for ICR services on the presumption that one session represents 1 hour of care. Therefore, we believe that it is appropriate to specify in the descriptors of the HCPCS codes for ICR services that one unit of the code represents 1 hour of care. As discussed previously, CR is covered for up to 36 1-hour sessions, with a minimum of 1 session per week and a maximum of 2 sessions per day, and Medicare contractors have authority to approve additional sessions, up to 72 sessions, over an additional period of time. Section 144(a)(1) of the MIPPA authorizes coverage of ICR programs in a series of 72, 1-hour sessions, up to 6 sessions per day, over a period of 18 weeks.

9. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions—Pulmonary Rehabilitation Services

Section 144 of the MIPPA amended Title XVIII of the Act to provide for coverage of pulmonary rehabilitation (PR) under Part B, under certain conditions, for services furnished on or after January 1, 2010. This final rule with comment period implements the new Medicare standards for a pulmonary rehabilitation program and establishes the requirements for furnishing such items and services to Medicare beneficiaries with chronic obstructive pulmonary disease (COPD).

COPD is one of the more common and severely debilitating chronic respiratory diseases, exemplified by chronic bronchitis and emphysema. Other conditions in this category include

persistent asthma, bronchiectasis, primary pulmonary hypertension, obesity-related respiratory disease, and ventilator dependency. This rule implements section 144(a) of the MIPPA to permit coverage and payment and to establish guidelines and standards as required by the statute.

a. Background

A PR program is typically a multidisciplinary program, individually tailored and designed to optimize physical and social performance and autonomy of care for patients with chronic respiratory impairment. The main goal is to empower and facilitate the individuals' ability to exercise independently. Exercise is combined with other training and support mechanisms to encourage long-term adherence to the treatment plan. The appropriate PR program will train and motivate the patient to attain his or her maximum potential in self-care and overall quality of life.

Prior to the MIPPA, some components of a pulmonary rehabilitation program were covered in office settings as individual services or as services incident to physician services.

b. Statutory Provisions of Section 144 of the MIPPA

In pertinent part, section 144 of the MIPPA amended section 1861(s)(2) of the Act to add a new subparagraph (CC) establishing coverage and payment of items and services furnished under a ''pulmonary rehabilitation program.'' A pulmonary rehabilitation program is defined in new subsection (fff)(1) to mean a ''physician supervised program'' that furnishes several specific items and services. Pulmonary rehabilitation consists of certain mandatory components including all of the following:

- Physician-prescribed exercise.
- Education or training (to the extent that the education and training is closely and clearly related to the individual's care and treatment and is tailored to such individual's needs).
- Psychosocial assessment.
- Outcomes assessment.
- Other items and services determined by the Secretary to be appropriate under certain conditions.

These mandatory components are to be provided in physicians' offices, hospital outpatient settings, and other settings determined appropriate by the Secretary.

A physician must at all times be immediately available and accessible for medical consultation and medical emergencies when PR items and services are being furnished under the program. The individual's treatment is furnished under a written treatment plan for each beneficiary participating in a PR program. The plan is developed by a physician in conjunction with the interdisciplinary team. A physician, who is involved in the patient's care and has knowledge of his or her condition, must establish and review the plan and it must be signed by a physician every 30 days. This plan must include the individual's diagnosis, the scope of services to be provided in terms of type, amount, frequency and duration, and the goals set for the individual. To be covered and receive payment from Medicare, the PR program must provide all of the specified mandatory items and services.

The statute authorizes the Secretary to establish standards for the physician supervising the PR program to ensure the physician has expertise in the management of individuals with respiratory pathophysiology and is licensed by the State in which the PR program is offered. These standards ensure that the physician is responsible for the program and, in consultation with appropriate staff, is involved substantially in directing the progress of individuals in the program.

c. Provisions of the Proposed Regulation

We proposed to add § 410.47, ''Pulmonary Rehabilitation Program: Conditions of Coverage'' to our regulations. The following is a summary of our proposals from the CY 2010 PFS proposed rule. For the full text, please see the CY 2010 PFS proposed rule (74 FR 33610 through 33614, and 33673 through 33674).

We proposed several definitions with respect to the services related to PR. These were for:

- Pulmonary rehabilitation.
- Individualized treatment plan.
- Outcomes Assessment.
- Physician.
- Physician-prescribed exercise.
- Psychosocial assessment.

We also proposed that Medicare would cover PR for beneficiaries with moderate (Stage II) to severe COPD (Stage III) when referred by the physician treating chronic respiratory diseases. Moderate and severe COPD was defined using the GOLD classification II and III.

We proposed that any additional covered clinical indications for the PR program would be added using the National Coverage Determination process.

We proposed that all PR programs must have the following components:

- Physician-prescribed exercise;
- Education or training;
- Psychosocial assessment;
- Outcomes assessment; and
- An individualized treatment plan.

The individualized treatment plan must be established, reviewed, and signed by a physician (as defined in section 1861(r)(1) of the Act) every 30 days.

The MIPPA provisions also authorized the Secretary to include other mandatory items and services within the scope of the PR program under certain conditions. We did not propose any other items or services. However, we stated that if we determine that the addition of any other items or services is appropriate, additions will made and implemented through future rulemaking.

We proposed that PR may be provided in a physician's office or in a hospital outpatient setting. If we determine that additional settings are appropriate, those settings will be added through future rulemaking. All settings should have all equipment and staff necessary to provide statutorily-mandated items and services.

We proposed that physicians furnishing PR items and services must have expertise in the management of individuals with respiratory pathophysiology and be licensed in the State in which the PR program is offered.

In the CY 2010 PFS proposed rule with comment period (74 FR 33613), we discussed that section 144 of the MIPPA includes requirements for immediate and ongoing physician availability and accessibility at all times for both medical consultations and medical emergencies when items and services are being furnished under the program. We proposed to define such availability in accordance with existing definitions for direct physician supervision services furnished in physician offices and hospital outpatient departments at § 410.26(a)(2) (defined through cross reference to § 410.32(b)(3)(ii)) and § 410.27(f), respectively. We stated that direct supervision, as defined in the regulations, is consistent with the language of the MIPPA because a physician must be present and immediately available where and when the items and services are being furnished. A physician must also be able to furnish assistance and direction throughout the performance of the services, which would include medical consultations and medical emergencies.

For PR services furnished in physicians' offices and other Part B settings paid under the PFS, we stated that this means that the physician must be present in the office suite and immediately available to furnish

assistance and direction throughout the performance of the service or procedure in accordance with § 410.26(a)(2) and (b)(5). It does not mean that the physician must be in the same room when the service or procedure is performed.

For PR services furnished in hospital outpatient settings, we stated that direct physician supervision is the standard set forth in the April 7, 2000 OPPS final rule with comment period (68 FR 18524 through 18526) for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. We currently define and specify the requirement for direct supervision for services provided in provider-based departments of hospitals at § 410.27(f). For this purpose, the physician must be on the premises of the location (meaning the provider-based department) and immediately available to furnish assistance and direction throughout the performance of the procedure. This does not mean that the physician must be present in the room when the procedure is performed.

The MIPAA provisions state that in the case of items and services furnished under such a program in a hospital, physician availability shall be presumed. As we have stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68702 through 68704), the longstanding presumption of direct physician supervision for hospital outpatient services means that direct physician supervision is the standard and we expect that hospitals are providing services in accordance with this standard.

We proposed that up to 36 sessions in the facility setting are appropriate, no more than one session per day. Patients should generally receive 2 to 3 1-hour sessions per week. We solicited comments regarding the proposed number of sessions. We addressed these comments in the response to public comment section of this final rule with comment.

d. Analysis and Response to Public Comments

We received many public comments on various provisions of our proposed rule. Comments were generally supportive of the new PR program but requested some changes related to the sessions and covered conditions. Commenters were in support of our definitions of pulmonary rehabilitation, individual treatment plan, psychosocial assessment, physician, and physician-prescribed exercise. The commenters also were supportive of the physician standards but asked for clarification of the direct supervision rules. The commenters suggested that we add language acknowledging the role and use of the PR staff/interdisciplinary team.

We also received comments related to NCDs but they were largely focused on the effect of the rule on current local coverage determinations (LCDs). Commenters did not request the addition of new items and services. We received a few comments regarding the addition of settings for PR, such as the CORF.

We received numerous comments noting that in the CY 2010 OPPS/ASC proposed rule with comment period (74 FR 35362 through 35370), we proposed that certain NPPs may supervise hospital outpatient therapeutic services that are within their State scope of practice and hospital granted privileges, provided that they also continue to meet all other requirements. Commenters requested that we allow the use of NPPs for PR services because NPPs may provide and supervise other therapeutic services in the HOPD. We received several significant comments and are providing our responses below.

Comment: We received comments requesting that we expand coverage to another level of COPD, very severe COPD (Stage IV). The commenters stated that very severe COPD should be included since the GOLD guidelines recommend PR for patients with Very Severe COPD (Stage IV). The commenters also cited the NETT trial in which they state that the very severe COPD patients had significant improvement as a result of the PR program.

Response: As a result of the comments, we are expanding the final policy and adding very severe COPD (Stage IV) as a covered condition. Based upon the evidence cited by the commenters and our own independent evidence review. We believe it is appropriate to allow coverage for COPD for the PR program. Commenters provided evidence from the National Emphysema Treatment Trial (NETT) which included patients with very severe COPD who were required to participate in pulmonary rehabilitation; trial results showed this sample of patients had significant improvement in exercise, dyspnea, and quality of life. Commenters also provided 2008 GOLD guideline evidence which supports the addition of very severe COPD. They cited GOLD guidelines which identify PR as the standard of care for patients with COPD stages II–IV and that all COPD stages benefit from an exercise program. Specifically, included in this patient population, the GOLD guidelines support PR for individuals with very severe COPD (Stage IV), while also suggesting consideration of surgical treatments. To the extent this patient group is able to engage in all of the mandatory components, including aerobic exercise, we believe patients would experience a clinical benefit. GOLD classification IV (Very Severe COPD) is defined as FEV1/FVC 70 percent and FEV1 <30 percent of predicted or FEV1 <50 percent predicted plus chronic respiratory failure.

Comment: We received numerous comments requesting that we expand coverage to a variety of other chronic respiratory conditions in addition to the proposed ones, (moderate to severe COPD). Most of the major respiratory care organizations submitted substantial comments pertaining to this issue. The conditions for which expansion was requested include cystic fibrosis, interstitial lung disease, restrictive chest wall disease, pulmonary hypertension, respiratory disorders associated with obesity, lung cancer, very severe COPD (stage IV), and bronchiectasis. The commenters requested that we add all of the requested conditions in the final rule, because the commenters allege substantial clinical benefit for all of them from a PR program.

Response: We proposed to use the national coverage determination process to consider expanding coverage of PR for other chronic respiratory diseases should adequate evidence support these additional uses. While the statute would permit expansion to other respiratory conditions, the data reviewed thus far did not substantiate the clinical benefit of PR for conditions beyond COPD. In making determinations for national coverage, the Medicare program is an evidence-based program. The chronic respiratory disease population is a highly clinically diverse patient population. As such, determining the appropriate conditions for coverage within the patient population requires a thorough review of existing evidence to meet the ''reasonable and necessary standard'' in accordance with section 1862(a)(1)(A) of the Act.

In this final rule with comment period, we announce that we will consider other conditions for which a PR program can be used through the NCD process. The number of various respiratory diseases is expansive and variance within the stages of each disease is broad. The need for, and benefit of, a PR program may relate to the specific respiratory function rather than a broad category of diseases. The NCD process will enable us to evaluate

the medical and scientific evidence to properly ascertain the specific conditions, and appropriate patients for whom a PR program is most beneficial. However, in the interim, until the NCD process is complete, the respiratory services previously allowed by local contractors for other medical conditions under other part B benefit categories remain in effect.

Comment: Some commenters requested that we add all of the requested conditions in the final rule because the commenters believe the proposed rule will supersede existing LCDs which currently allow some respiratory/pulmonary type services for a variety of other chronic respiratory lung diseases, including COPD.

Response: As explained above, we do not agree that the limitation of PR programs to one covered condition (moderate to very severe COPD) through the final rule will eliminate the ability of beneficiaries to obtain other respiratory services that are available under local coverage decisions based on other benefit categories. The individual respiratory services currently covered do not constitute a comprehensive PR program but individualized services that may also be components of a program. Accordingly, to the extent these existing individual respiratory services are reasonable and necessary, a local contractor may still cover them. If the patient has COPD that qualifies for coverage of pulmonary rehabilitation under this final rule with comment period, we would expect to see services furnished under the PR program and billed using the specific PR code. To the extent the provider is billing for the comprehensive PR code, the PR program implemented must meet all of the requirements outlined herein and be the only PR service billed. To the extent we add other conditions through the NCD process, some LCDs may become obsolete in the future.

Comment: We received a significant number of comments regarding the number of sessions for the PR program. Some commenters stated that our proposal of 36 sessions does not reflect the standard of care nationally. Commenters recommended that we allow between 60 and 72 sessions and allow more than one session per day, based in part on the experience of the Lung Volume Reduction Surgery patients in the NETT trial. Under that trial, certain patients were allowed a total of 30 sessions, each required to be minimally 2 hours in duration. Other commenters noted that the typical PR sessions may average 2 hours or more. The major professional organizations requested 72 hours of pulmonary rehabilitation, ''based on the individual's medical necessity and reaching a level of optimal care''.

Response: We agree with commenters that additional sessions may be appropriate in some circumstances. However, any PR program, due to the broad spectrum of patients, inherently necessitates a very individualized plan of treatment. Therefore, in this final rule with comment period, we are authorizing our contractors to approve up to an additional 36 sessions when medically necessary. This would provide qualifying beneficiaries access of up to 72 sessions of PR when appropriate.

Even within the population of patients with moderate to very severe COPD, an individual's ability to participate in additional sessions would require a specific review of evidence to determine whether an additional 36 sessions are warranted under section 1862(a)(1)(A) of the Act. This case-by-case expansion allows greatest flexibility for individual needs. It also takes into account the short term nature of the program based on lifestyle modification goals towards self management of the disease. Since the programs are highly individualized, we do not specify a duration by which sessions must be completed; this allows the possibility of sessions, if necessary, up to the maximum allowable of 72, over a longer period of time.

Comment: We received a number of comments regarding the number of sessions per day for the PR program. Some commented that our proposed sessions do not reflect the standard of care nationally. Commenters recommended that we allow more than one session per day.

Response: We agree with commenters that some patients may be capable of more than one PR session per day. The patient with very severe COPD may not be able to participate in a prolonged aerobic exercise session, and may benefit from 2 shorter periods of aerobic exercise within each session. Also, two sessions will facilitate greater logistical ease for those in rural areas who may want to do multiple sessions in a day, for example, morning and afternoon, and/or provide an opportunity for more compromised COPD patients to engage in two shorter aerobic sessions in a day. Therefore, we will allow up to two 1-hour sessions per day.

Comment: Some commenters asked that we include language in this regulation which minimally refers to the use of, and role of, the interdisciplinary team and/or PR staff.

Response: We agree that the disciplinary team/PR staff play an important role under the direction of the physician. These team members may include, but are not limited to, nurses, social workers, respiratory therapists, and dietitians. (See regulations text, ''Physician standards''.) We have revised § 410.47(e)(1) to emphasize this point.

Comment: Several commenters requested that we allow NPPs to provide the direct supervision, rather than requiring supervision by a physician in accordance with the definition in section 1861(r)(1) of the Act.

Response: The statutory language of the MIPPA defines pulmonary rehabilitation as a ''physician-supervised'' program. A physician is defined in section 1861(r)(1) of the Act. The MIPAA also specifically requires that ''a physician is immediately available and accessible for medical consultation and medical emergencies at all times items and services are being furnished under the program, except that in the case of items and services furnished under such a program in a hospital, such availability shall be presumed.'' The text of the statute uses the word ''physician'' and does not include NPPs. We believe, based on the statutory language in MIPPA for pulmonary rehabilitation programs, that the statute does not provide us the flexibility to allow the supervising role to be filled by a non-physician practitioner. In other words, for the purposes of PR programs, whether furnished in a physician's office or hospital outpatient setting, the direct physician supervision definition applies only to a physician as defined in section 1861(r)(1) of the Act. As discussed previously, the supervision requirement is satisfied if the physician meets the requirements for direct supervision for physician office services at § 410.26 and for hospital outpatient services at § 410.27. The final policies for payment and direct physician supervision of PR services furnished to hospital outpatients are discussed in detail in section XII.B.2 and B.4 of the CY 2010 OPPS/ASC final rule with comment period.

Comment: A few commenters requested that we provide a session which is ''no more than 1 hour''. The commenters believe that for some individuals, an hour would be the maximum time they could physically participate due to their compromised condition.

Response: We disagree. We believe that a maximum of 1 hour would not afford sufficient time for most patients to receive both the mandatory aerobic exercise and any other component services. Those in rural areas may want

to participate in longer sessions due to travel logistics.

Comment: One commenter proposed that we require at least 30 minutes of exercise.

Response: We disagree. Imposing a strict standard of minimal 30 minutes of exercise is not realistic; the programs are highly individualized. Many patients may not, at least initially, be able to participate in thirty minutes of aerobic exercise.

Comment: One commenter suggested we use the Silver Sneakers program at the YMCA for PR in the Medicare program. The commenter remarked it costs only $40 per month.

Response: While we generally encourage beneficiaries to exercise, we do not agree that this particular suggestion would be feasible. We do not expect that a typical YMCA would meet the statutory requirements related to physician standards and supervision, or perhaps the facility standards for safety and equipment. Further, YMCAs are not currently recognized as Medicare suppliers or providers.

Comment: A few commenters requested that we include a CORF as a PR setting.

Response: While the statute would allow the Secretary to cover PR in additional settings, we are not expanding the settings in this final rule. The CORF statutory definition, in section 1861(cc) of the Act, provides requirements for all services provided in that facility type. The CORF facility does not meet the supervision requirements imposed by the MIPPA. In accordance with section 1861(cc)(1) of the Act, the term ''CORF'' provides, in part, ''comprehensive rehabilitation facility means a facility which—(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative service to outpatients for the rehabilitation of *injured*, *disabled*, or sick persons.'' (Emphasis added)

''(B) provides at least the following comprehensive outpatient following rehabilitative (i) physicians' services (rendered by physicians, as defined in section 1861 (r) (1) who are available at the facility on a full or *part-time* basis;'' (Emphasis added). The definition of services and reference to the injured or disabled population is consistent with the mandate for rehabilitative services, which we maintain are not directed towards the chronically ill patients with respiratory disease such as COPD. The CORF statutory provisions allow a physician to be in the facility part-time. This conflicts with the MIPPA provisions for the physician supervision, that is, being immediately available and accessible at all times items services are being furnished under the program. However, the MIPPA PR program does not eliminate or affect the PT services provided in accordance with the CORF regulations at § 410.100. Initially, a COPD patient may be in need of PT services (in or outside of a CORF) in order to strengthen their muscles to prepare for the PR program. By clarifying the services in a CORF, which are mandated to include a majority of physical therapy, we sought to delineate these services from those provided in a PR program focused on the condition of COPD.

Comment: Commenters support the requirement that a physician must create an individualized plan of treatment for pulmonary rehabilitation. However, some commenters requested that we clarify whether we intend that physicians must personally create each plan of care or whether physicians may review and approve a plan of care created by pulmonary rehabilitation staff.

Response: A physician must establish the individualized treatment plan; however, there can be input from the pulmonary rehabilitation staff with respect to the plan.

The MIPPA provisions require that PR services be provided under written individualized treatment plans ''established, reviewed, and signed by a physician every 30 days.'' The individualized plan includes the individual's diagnosis, the types of services appropriate, the frequency and duration, and the treatment goals. This plan may initially be developed by the referring physician or the PR physician. If the plan is developed by the referring physician who is not the PR physician, the PR physician must also review and sign the plan prior to initiation of PR. The PR staff may make recommendations for modifications to the program, but the physician will still modify the plan as needed, and review and sign the plan every 30 days.

e. Provisions of the Final Rule

In the final rule we are adopting the provisions as set forth in the July 2009 proposed rule with the following revisions:

- Based on public comments and the GOLD guidelines we are expanding coverage to include individuals with very severe COPD (Stage IV) as a covered condition. We are modifying the final rule § 410.47 (b)(1) ''Beneficiaries who may be covered'', to state the addition. The GOLD standard evidence defines GOLD classification IV (Very Severe COPD) as FEV1/FVC 70 percent and FEV1 <30 percent of predicted or FEV1 <50 percent predicted plus chronic respiratory failure.
- We expanded section § 410.47(f) to include additional sessions by changing the total number of allowable sessions to 72 sessions; we did so by allowing an additional 36 at contractor discretion when medically necessary. We also expanded the daily number of the allowable sessions from one session to two sessions.
- We added definitions in § 410.47(a) for the ''Medical director'' and the ''Supervising physician''.

In addition, we are making the following clarifying and technical changes:

- We clarified in § 410.47(c)(5) that the physician establishing the treatment plan needs to be one who is involved in the patient's care and has knowledge of his or her condition.
- We added language in § 410.47(e)(1) to clarify the physician interaction with PR staff.
- We added the word ''medicine'' in § 410.47(e)(4) to conform the rule to the MIPPA statutory language.
- We added language in § 410.47(e)(3) for training requirements related to the use of emergency equipment; this correlates to the established requirements in the proposed rule for availability of this equipment.
- We added in § 410.47(f) the words ''up to'' to clarify the contractor is permitted to prescribe any additional amount lower than, and up to, 36 sessions based on medical necessity. We also added a reference to the pertinent statute.

f. Coding and Payment

We proposed to create one HCPCS code to describe and to bill for the services of a PR program as specified in section 144(a) of the MIPPA, GXX30 (now assigned code number G0424, *Pulmonary rehabilitation, including aerobic exercise (includes monitoring), per session, per day)*. This G-code is to be billed when the patient performs physician-prescribed aerobic exercises that are targeted to improve the patient's physical functioning and may also include the other aspects of pulmonary rehabilitation, such as education and training. Because the physician's role in the PR program is defined in a similar manner to that in the cardiac rehabilitation program, we stated that the physician work component should be analogous to that of CPT code 93797, *cardiac rehab without telemetry*. Therefore we proposed work RVUs of 0.18 RVUs for this new G-code. Using this same reference code, we proposed

that the malpractice RVUs would be 0.01 RVUs.

To establish the PE RVU payment for the proposed new PR G-code, we reviewed the PE inputs of similar services, particularly those of the respiratory therapy HCPCS codes, G0237 and G0238, as well as the cardiac rehabilitation codes, CPT codes 93797 and 93798 for non-facility settings. Given that various individuals, acting under the supervision of a physician, can make up the PR multidisciplinary team, we proposed that the clinical labor for the PR G-code could be best represented by the following labor types taken from the PE database: the nurse ''blend'' (RN/LPN/MTA), the respiratory therapist (RT), the social worker/psychologist and the medical/technical assistant—which we selected to represent various specialists involved in furnishing this service; these are valued at $0.37, $0.42, $0.45, and $0.26 per minute, respectively. Using an average of these values, $0.375 per minute, we proposed to use the nurse blend labor type found in the cardiac rehabilitation CPT codes, at $0.37 per minute, as the typical value for the PR clinical labor and assigning 28 minutes of clinical labor time for the new PR G-code based on the various components of the proposed PR program.

For the equipment PE inputs, we reviewed the direct PE inputs for similar existing codes and proposed a pulse oximeter (with printer), a 1-channel ECG, and a treadmill. Since no typical supplies were listed for similar existing codes in the PE database, we did not propose any specific supplies for this proposed new G-code.

The following is a summary of the comments we received regarding payment for pulmonary rehabilitation services under section 144(a) of the MIPPA.

Comment: Some commenters asked that we confirm that the services of physical therapists are not part of the PR, CR, or ICR benefits authorized by section 144(a)(1) of the MIPPA and are always paid under the physical therapy benefit and that, therefore, the therapy services do not require physician supervision when furnished as part of a PR, CR, or ICR program, including in the HOPD.

With regard to PR, some commenters stated that we have a longstanding history of recognizing the services of a therapist as an integral part of a PR program and requiring that these services be reported and paid as PT services. Specifically, the commenters indicated that in the CY 2002 PFS final rule (66 FR 55246) and in the current Medicare Claims Processing Manual (Pub. 100–04, Chapter 5, section 20.A), we specify that when physical therapists treat respiratory conditions, they should report CPT codes for PT in the 97000 series and should not report HCPCS codes G0237, *Therapeutic procedures to increase strength or endurance of respiratory muscles, one on one, face to face, per 15 minutes (includes monitoring);* G0238, *Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, one on one, face to face, per 15 minutes (includes monitoring);* or G0239, *Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring).* The commenters added that in the September 25, 2007 Decision Memo for Pulmonary Rehabilitation (CAG–00356N), CMS recognized the importance of PT to patients with pulmonary conditions and stated that these services should be billed and paid under the PT benefit. The commenters stated that a plan of care developed by a physical therapist to improve pulmonary function for a patient with chronic obstructive pulmonary disease (COPD), which meets the medical necessity criteria for PT services, is covered and paid under the PT benefit. The commenters explained that the therapy plan of care is separate from the benefits authorized by section 144(a)(1) of the MIPPA. The commenters believe it should continue to be reported under the CPT codes for PT services, and should be paid under the PT benefit.

In addition, with regard to CR/ICR, the commenters requested that CMS confirm that skilled PT services that are rendered in the CR setting by a qualified physical therapist should be conducted, reported, and paid as PT services, and that physician supervision is not necessary in the CR setting when the physical therapist is delivering treatment that clearly meets the criteria for a PT service. The commenters explained that we have recognized and codified that PT is a separate benefit and that physical therapists are qualified to perform certain services independent of direct physician supervision. Similar comments were received concerning occupational therapy services.

Response: Section 144(a)(1) of the MIPPA authorized a new comprehensive PR benefit, and also codified specific benefits for CR and ICR. Therefore, we believe that outpatient Part B providers and suppliers should furnish the full scope of the PR, CR, or ICR benefit as comprehensive programs to those patients who qualify for coverage. We would not expect the component services of PR, CR, and ICR programs to be unbundled and billed separately by different providers or practitioners under other benefit categories, such as the PT benefit.

In the outpatient physicians office setting, we expect that most patients participating in PR, CR, or ICR programs authorized by section 144(a)(1) of the MIPPA and covered by Medicare will be debilitated based on their underlying medical condition, age, or other factors. In order to develop a PR, CR, or ICR treatment plan, some debilitated patients may require evaluations by therapists on the multidisciplinary team, in addition to assessments by other team members. In order to participate successfully in the prescribed exercise component of the PR, CR, or ICR program, we also expect that these patients may receive individualized treatments by therapists on the multidisciplinary team and others to promote the increased functionality that is a principle goal of PR, CR, and ICR programs. As we stated in the CY 2010 PFS proposed rule, the items and services furnished by a CR or PR program are individualized and set forth in written treatment plans for each beneficiary (74 FR 33607 and 33611). We believe these evaluations and individualized treatments are a part of the PR, CR, or ICR program for those beneficiaries who need them. As such, we believe they should be conducted by one or more members of the multidisciplinary team of the PR, CR, or ICR program with the appropriate expertise.

While we have not defined PR, CR, or ICR services as always including therapists' services as part of the comprehensive benefit (74 FR 33608 and 33614), we have acknowledged in the CY 2010 PFS proposed rule that written treatment plans are highly individualized and that there should be flexibility in the type, amount, frequency, and duration of services provided in each session (74 FR 33607).

We expect that physical therapists could conduct assessments and individualized treatments as part of the PR, CR, or ICR program because physical therapists have the knowledge and skills to assist in addressing common problems that lead to physicians ordering PR, CR, or ICR services for their patients, including poor aerobic capacity, poor endurance, and shortness of breath, in the context of chronic pulmonary or cardiovascular disease. In the context of PR, while we also stated that individuals requiring PR services have a chronic respiratory

disease and are in need of supervised aerobic exercise, not PT, we acknowledged that patients require assessments to address individualized needs and the provision of a mix of services necessary to address those needs (74 FR 33613).

Patients in PR, CR, or ICR programs must receive the full complement of care as defined under these benefits as specified in section 144(a)(1) of the MIPPA, in accordance with their individualized treatment plan, including assessments and prescribed exercise. Additionally, the standard HCPCS coding guidance instructs practitioners and providers to report the code for the procedure or service that most accurately describes the service performed. As stated in Section 20.12.1.b. of Chapter 5 of the Medicare Contractor Beneficiary and Provider Communications Manual, in instances where several component services, which have different CPT/HCPCS codes, may be described in one more comprehensive code, only the single code most accurately describing the procedure performed or service rendered should be reported. Therefore, we would expect that when physical therapists provide evaluations and individualized treatment services under a PR, CR, or ICR treatment plan, these services would be billed as PR, CR, or ICR services under the PR, CR, or ICR CPT or Level II HCPCS G-codes that apply. When these programs are provided in a physician office setting and the physical therapist serves as a member of a multidisciplinary team, the services may not be separately billed as therapy services or as services incident to physician services and they need not follow the requirements of those policies. Services must be provided according to the policies for PR, CR, or ICR. For example, for therapy services in physician offices, qualifications of therapists, 90-day certification of plan of care, supervision by NPPs, treatment notes, and progress reports do not apply unless required by PR, CR, and ICR policies. As discussed in detail in sections II.G.8.e. and II.G.9.d. above in this final rule with comment period, for purposes of PR, CR, and ICR services, the required direct supervision must be provided by a doctor of medicine or osteopathy as defined in section 1861(r)(1) of the Act for all services furnished under the plan. For services provided in physician's offices, direct supervision is defined in accordance with existing requirements and the existing definition of direct physician supervision for all therapeutic services furnished in physician offices at § 410.26.

We continue to believe that direct supervision, as defined in the regulations, is consistent with the language of the MIPAA because a physician must be present and immediately available where services are being furnished. A physician must also be able to furnish assistance and direction throughout the performance of the services, which would include medical consultations and medical emergencies.

We expect that most patients who meet the diagnosis requirements for coverage of PR, CR, or ICR would receive component services covered under the PR, CR, or ICR benefit as part of a comprehensive PR, CR, or ICR program, subject to the coverage and payment policies that we are finalizing in this final rule with comment period and the CY 2010 OPPS/ASC final rule with comment period. We understand that some component services of PR, CR, or ICR have previously been furnished to beneficiaries and paid by Medicare under other benefits, such as the outpatient PT benefit.

As stated above, since section 144(a)(1) of the MIPPA authorized a new comprehensive PR program and legislated the CR benefit to also recognize ICR services, we believe that outpatient Part B providers and suppliers should furnish the components of PR, CR, or ICR as comprehensive programs to those patients who qualify for coverage. We would not expect the component services of PR, CR, and ICR programs to be unbundled and billed separately by different providers or practitioners under other benefit categories, such as the PT benefit. Therefore, we expect that it would be uncommon for a patient receiving care under a PR, CR, or ICR treatment plan to also be receiving PT services under a separate PT plan of care.

There may be patients with therapy needs that are outside the treatment plan appropriate for PR, CR, or ICR and such patients should receive medically necessary PT services specific to those other needs under a PT plan of care and according to the policies for PT services. However, we would not expect it to be the norm that PT services and PR, CR, or ICR services are furnished to the same beneficiaries in the same day. Clearly, a single period of care can only be billed as one type of treatment service, so providers and suppliers could never bill both PT and PR, CR, or ICR services for the same time period for the same patient (for example, during an hour session from 10 to 11 a.m. on a single date of service).

We plan to monitor claims data for PR, CR, and ICR services as well as any additional claims for therapy services. If we detect patterns of care that are inconsistent with our stated expectations for PR, CR, or ICR services and therapy services, we may encourage Medicare contractors to review cases in which a provider or supplier reports both types of services for the same patient during the same span of time (for example, over a several month period) or we may propose changes to our payment methodologies for these services.

After considering the public comments received, we are clarifying that we would expect component services that are furnished under a PR, CR, or ICR treatment plan to beneficiaries who qualify for PR, CR, or ICR services to be furnished as PR, CR, or ICR services, regardless of whether they are furnished by a physical therapist or other healthcare practitioner, and that all of the coverage and payment requirements, including, but not limited to, the physician supervision requirements for services incident to a physician in the physician office setting, apply to those PR, CR, or ICR services. We expect that providers and suppliers of Part B services will furnish the comprehensive set of services that is described in the criteria for PR, CR, or ICR programs to beneficiaries who qualify for the benefit.

Similar comments were expressed concerning the inclusion of occupational therapy services in PR programs. The policies for occupational therapy services are the same as for physical therapy services.

Comment: Some commenters believed there were flaws in our method of determining the payment rate. The commenters did not agree that the physician work in pulmonary rehabilitation mirrors the physician work in cardiac rehabilitation without telemetry (CPT 93797). The commenters stated that CPT code 93797 has 11 minutes of physician time, but we applied a similar payment for a minimum of 60 minutes of PR service. Some commenters thought we should multiply the physician work RVUs of CPT code 93797 by 4 for a 60-minute session. Some commenters also stated that the respiratory therapy services paid by the G-codes currently are valued at about $15–20 for each 15 minutes of service and that we are proposing to pay $16 for a 1-hour session which is not enough to cover and pay for the services required.

Response: We do not agree that the physician work is substantially different in CR than in PR. We do not expect that the physician work for a 60-minute PR session equals 60 minutes. We believe the work is performed primarily by the multidisciplinary team, and not the physician. The current G-codes were valued for respiratory therapy services and not for a comprehensive pulmonary rehabilitation program.

Comment: Some commenters stated that our staffing and equipment assumptions were not valid. For example, some commenters stated that the list of individuals recommended by the guidelines for PR should be reflected by those included in the PE for PR. Commenters stated that PR includes review of data that is comparable to telemetry, such as EKG and oximetry. The commenters indicated that the equipment needed for PR should be included in the payment.

Response: We anticipate that a variety of team members will contribute to PR during a session, and we have blended the values of the types of staff that we believe would most commonly be used. In response to the comments, we have increased the variety of team members included in the mix. However, we have not included physical therapists or occupational therapists in the PE because we anticipate that beneficiaries who are eligible for the PR program will not typically require physical therapy as part of their PR program. If a therapist does participate as a member of the team, we believe that therapist typically would be furnishing PR services to meet PR goals that do not require the skills of a therapist. In addition, we have revised the PE to include more equipment as requested.

Comment: Several commenters requested that the pulmonary rehabilitation code exclude certain services that they would like to bill separately, especially the 6 minute walk test, outcomes assessments, 30 day reviews, physician E/M services, therapy codes, the current G0237–9 codes, and related services such as 94620, 94667, and 94667. The commenters stated that bundling the services of the PR program will result in reduced payment rates that could shut down PR programs.

Response: The pulmonary rehabilitation therapy G-codes were developed for a comprehensive pulmonary rehabilitation program as described in the statutory benefit. All of the services of the program are included in the payment. We would expect that an individual who is receiving PR services would receive the full complement of services within the PR program and that these services would be billed using the PR HCPCS code G0424. We recognize that an individual may require additional medically necessary services such as physician E/M or physical therapy, outside of the PR plan of care. However, as we noted above, we will monitor billing patterns to assess whether the full scope of services is being furnished to patients under PR treatment plans. If we detect patterns of care that are inconsistent with our expectations, we may encourage Medicare contractors to review cases in which a provider or supplier reports services for the same patient during the same span of time that might be considered part of a PR treatment plan, and as a result, we may propose changes to our payment methodologies for these services.

Comment: Some commenters requested that the current HCPCS G-codes for therapeutic procedures for respiratory function (G0237, G0238 and G0239) continue to be used to bill for pulmonary rehabilitation, E/M, and diagnostic services for pulmonary rehabilitation programs.

Response: The current HCPCS G-codes were developed for use in CORFs and other settings to describe the provision of respiratory therapy services. They continue to be appropriate for use in CORFs for this purpose. Outside of the CORF setting those codes are not appropriate for use in office settings to provide pulmonary rehabilitation services under the new pulmonary rehabilitation program as defined by the MIPAA. The pulmonary rehabilitation benefit was added by Congress for the purpose of covering services for patients with certain pulmonary conditions who require a coordinated program of treatment.

The existing HCPCS G-codes do not represent the full scope of services in a comprehensive PR program now authorized by the new PR benefit. We want to ensure that when a physician office bills and is paid for PR services that it attests to meeting all of the requirements of the comprehensive PR program by the reporting of a HCPCS G-code specific to a PR session. We would expect beneficiaries who could qualify for a PR program, where a program is available, to receive services related to those conditions in such a program rather than having services unbundled and provided separately outside a PR program. Therefore, specific codes have been developed to identify and make payment for services furnished as part of pulmonary rehabilitation programs. However, a beneficiary who was receiving treatment in a CORF and in need of respiratory therapy services could receive those services and the CORF could bill using the existing G-codes, as they would have prior to the MIPPA.

Comment: Many commenters expressed concern about the duration of the PR session which we proposed as a minimum of 1 hour. The commenters alleged the session is *capped* at 1 hour and requested longer sessions. The commenters maintained that the typical PR session is a minimum duration of 2 to 3 hours.

Response: We did not cap the length of the session at 1 hour, but proposed to require a minimum of 1 hour of treatment. Implied in these comments is justification for a higher payment rate, related to a longer duration for a session. In response to comments requesting longer treatments, we are adding the phrase ''per hour'' to the new HCPCS code G0424 descriptor to conform the descriptor of the code to the basis for the payment being made for one unit of the code and to enable suppliers to determine when one session of PR ends and the second session begins. The code descriptor is G0424, *Pulmonary rehabilitation, including exercise (includes monitoring), per hour, per session.*

In addition, we are modifying our final policy to cover up to 2 sessions of PR per day.

After reviewing the public comments, we will finalize our proposals with modifications. In summary, we will:

- Change the HCPCS code descriptor as follows: G0424, *Pulmonary rehabilitation, including aerobic exercise (includes monitoring), per hour, per session.*
- As discussed above, we will also allow up to two sessions of PR per day.
- Modify PE inputs, as recommended by commenters, resulting in increased PE RVUs. However, we continue to believe the physician work for PR is comparable to CR and will make no changes to the work RVUs.

10. Section 144(b): Repeal of Transfer of Title for Oxygen Equipment

a. Payment Rules for Oxygen and Oxygen Equipment

(i) Overview

The general Medicare payment rules for durable medical equipment (DME) are set forth in section 1834(a) of the Act and 42 CFR part 414, subpart D of our regulations. Section 1834(a)(1) of the Act and § 414.210(a) of our regulations establish the Medicare payment for a DME item as equal to 80 percent of either the lower of the actual charge or the fee schedule amount for the item. The beneficiary coinsurance is equal to

20 percent of either the lower of the actual charge or the fee schedule amount for the item once the deductible is met.

Specific rules regarding payment for oxygen and oxygen equipment are set forth in sections 1834(a)(5), (a)(9), (a)(14) and (a)(21) of the Act and § 414.226 of our regulations. Suppliers are paid a monthly payment amount for furnishing medically necessary stationary oxygen equipment under the class described in § 414.226(c)(1)(i) and oxygen contents (for both stationary and portable). Equipment in the stationary class includes stationary oxygen concentrators, which concentrate oxygen from room air; stationary liquid oxygen systems, which use oxygen stored as a very cold liquid in cylinders and tanks; and gaseous oxygen systems, which administer compressed oxygen directly from cylinders.

We also pay a monthly add-on payment to suppliers furnishing medically necessary portable oxygen equipment falling under one of two classes described in § 414.226(c)(1)(ii) and (iii). Equipment in these classes includes traditional portable equipment that includes portable liquid oxygen systems and portable gaseous oxygen systems and oxygen generating portable equipment (OGPE) that includes portable oxygen concentrators and oxygen transfilling equipment used to fill portable tanks or cylinders in the home. Both the liquid and gaseous oxygen systems (for stationary and portable) require on-going delivery of oxygen contents.

(ii) Provisions of the Deficit Reduction Act of 2005 (DRA)

Section 5101(b) of the DRA amended section 1834(a)(5) of the Act by limiting monthly rental payments to suppliers for oxygen equipment to 36 months of continuous use. At the end of this 36-month rental period, suppliers were required to transfer title of the oxygen equipment to the beneficiary. This requirement started for existing beneficiaries using oxygen on January 1, 2006 and new beneficiaries using oxygen on or after January 1, 2006. The provision also required payments for oxygen contents continue after title to the equipment has been transferred. In the November 9, 2006 **Federal Register**, we issued the ''Home Health Prospective Payment System Rate Update for CY 2007 and Deficit Reduction Act of 2005 Changes to Medicare Payment for Oxygen Equipment and Capped Rental Durable Medical Equipment'' final rule (71 FR 65884) to implement these DRA changes. We amended § 414.226 to clarify that the monthly rental payments for items falling under the classes now described in § 414.226(c)(1)(i) thru (iii) are made for periods of continuous use not to exceed 36 months. We revised the rules regarding a period of continuous use for the rental of DME in § 414.230 of our regulations to clarify the continuous use determination. We also added § 414.226(f) requiring a supplier to transfer title to the oxygen equipment to the beneficiary on the first day after the 36th continuous month in which payment is made for the equipment. In addition, we revised § 414.226 to allow monthly payments to suppliers for furnishing gaseous or liquid oxygen contents for use with either beneficiary-owned stationary equipment or beneficiary-owned portable equipment.

Section 5101(b) of the DRA also authorized payments for maintenance and servicing of beneficiary-owned oxygen equipment if the Secretary determined such payments to be reasonable and necessary. We determined that paying for necessary repairs and periodic maintenance and servicing of beneficiary-owned oxygen equipment was reasonable and necessary to ensure that oxygen equipment owned by beneficiaries continued to function properly. Without these payments, we were concerned that there was little incentive for suppliers to maintain this equipment, because the equipment was no longer owned by the supplier.

In the November 9, 2006 final rule, we established other safeguards for beneficiaries receiving oxygen and oxygen equipment, which are set forth at § 414.210(e)(5) and § 414.226(g). Section 414.210(e)(5) requires suppliers—after transferring title of the oxygen equipment to the beneficiary—to furnish replacement equipment at no cost to the beneficiary or the Medicare program if the item furnished by the supplier does not last (that is, it breaks down and is irreparable) for the entire reasonable useful lifetime established for the equipment in accordance with § 414.210(f)(1). Per § 414.210(f), a beneficiary is allowed to elect to receive new oxygen equipment if the original equipment has been in continuous use by the beneficiary for the equipment's reasonable useful lifetime. Section 414.210(f)(1) states the reasonable useful lifetime for equipment is determined through program instructions. In the absence of program instructions, the carrier may determine the reasonable useful lifetime for equipment, but in no case can it be less than 5 years. Computation is based on when the equipment is delivered to the beneficiary, not the age of the equipment. If the beneficiary elects to obtain new oxygen equipment after the reasonable useful lifetime, the payment is made in accordance with § 414.226(a). Section 414.226(g)(2) prohibits suppliers from replacing oxygen equipment prior to the expiration of the 36-month rental period unless a specific exception applies. This was intended to protect the beneficiary from the supplier changing the beneficiary's equipment in order to maximize Medicare payments. For example, the supplier may want to move a beneficiary from a portable oxygen concentrator to portable gaseous equipment for which Medicare makes additional payments after the 36-month rental period ends.

Section 414.226(g)(4) provides that, by no later than 2 months before the date on which the supplier must transfer title to oxygen equipment to the beneficiary, the supplier must disclose to the beneficiary: (1) whether, in the case of oxygen transfilling equipment and stationary or portable oxygen concentrators, it can maintain and service the equipment after the beneficiary acquires title to it; and (2) whether, in the case of stationary or portable gaseous or liquid oxygen systems, it can continue to deliver oxygen contents to the beneficiary after the beneficiary acquires title to the equipment.

(iii) Provisions of Medicare Improvements for Patients and Providers Act (MIPPA) Section 144(b)—Repeal of Transfer of Ownership of Oxygen Equipment

In the CY 2009 PFS final rule with comment period, we outlined the provisions of section 144(b) of the MIPPA (73 FR 69875 through 69876). Section 144(b) of the MIPPA repeals the requirement that the supplier transfer title to oxygen equipment to the beneficiary after the 36-month rental period. In its place, section 144(b) establishes a 36-month rental cap and amends section 1834(a)(5)(F) of the Act by adding three new payment rules and supplier requirements for furnishing oxygen and oxygen equipment after the 36-month rental period. Each of these provisions is discussed below.

(a) Furnishing Oxygen Equipment After the Rental Cap

Under this new provision, the supplier that furnishes oxygen equipment during the 36-month rental period must continue to furnish the oxygen equipment after the 36-month rental period. The supplier is required to continue to furnish the equipment during any period of medical need for the remainder of the reasonable useful

lifetime of the equipment. Section 144(b) does not provide any exceptions to this requirement. For example, if the beneficiary relocates outside the supplier's normal service area at some time after the 36-month rental period but before the end of the reasonable useful lifetime of the equipment, the supplier must make arrangements for the beneficiary to continue receiving the equipment at his or her new place of residence. This responsibility is not transferred to another supplier. It is important to note that § 414.226(g)(1)(ii) does not apply this same requirement in situations where the beneficiary relocates during the 36-month rental period. We received comments from interested parties on whether this should be changed in light of the repeal of transfer of ownership of oxygen equipment and other recently enacted provisions of the MIPPA.

We revised § 414.226(f) to conform our regulations to this new requirement. We deleted the transfer of ownership requirement and added the new requirement that the supplier must continue furnishing the oxygen equipment after the 36-month rental period during any period of medical need for the remainder of the reasonable useful lifetime of the equipment.

In addition, we revised § 414.230 to specify that under no circumstance will a new period of continuous use begin following the 36-month rental period and before the end of the equipment's reasonable useful lifetime since the supplier is responsible for furnishing the equipment after the 36-month rental period for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. Regardless of the length of any break in medical need that occurs following the 36-month rental period, once the break ends and medical need for the oxygen equipment resumes, the supplier is obligated to continue furnishing the item for no additional rental payments until the end of the equipment's reasonable useful lifetime. If the equipment's reasonable useful lifetime ends during the break in medical need, the supplier is under no obligation to continue furnishing the equipment. However, in accordance with § 414.210(f), the beneficiary may elect to obtain new equipment in these situations. If the beneficiary elects to obtain new equipment, a new 36-month rental period begins. It is important to note that, in accordance with section 5101(b)(2)(B) of the DRA, in the case of beneficiaries receiving oxygen equipment on December 31, 2005, the 36-month rental period begins on January 1, 2006. However, in accordance with § 414.210(f)(1), the reasonable useful lifetime of durable medical equipment, including oxygen equipment, begins on the date that the equipment is first delivered to the beneficiary. The reasonable useful lifetime of oxygen equipment furnished to beneficiaries on December 31, 2005, is not adjusted to begin anew on January 1, 2006, to correspond with the start of the 36-month rental period. Therefore, in these situations, the equipment's reasonable useful lifetime may end at any point during or after the 36-month rental period depending on the first day the equipment was delivered to the beneficiary. In these situations, a new period of continuous use and a new 36-month rental period would begin if the beneficiary elects to obtain new equipment.

We also revised § 414.210(e)(2), (e)(4) and (e)(5) to delete regulatory text which relates to beneficiary ownership of oxygen equipment. In addition, we deleted § 414.210(e)(3) because beneficiaries will no longer own oxygen tanks and cylinders. Because § 414.210(e)(3) was deleted, we redesignated § 414.210(e)(4) and § 414.210(e)(5) as § 414.210(e)(3) and § 414.210(e)(4), respectively.

We also revised § 414.226 to state that the protection against supplier replacement of oxygen equipment, unless an exception applies, continues to be in effect after the 36-month rental period ends. Specifically, we revised § 414.226(g)(2) to indicate that this prohibition applies until the expiration of the reasonable useful lifetime established for the equipment. As discussed in the November 9, 2006 final rule (71 FR 65894), we believe this is a necessary safeguard for the beneficiary against changes in equipment made by the supplier in order to maximize payments resulting from moving from one modality to another. Finally, we deleted § 414.226(g)(4) because the transfer of ownership of oxygen equipment provision has been repealed, rendering this provision inapplicable.

The following is a summary of the comments we received and our responses.

Comment: Numerous commenters requested a delay in the implementation of the 36-month rental cap on oxygen and oxygen equipment. Many commenters expressed concerns about the impact of the 36-month cap on suppliers. Some commenters stated the amendments of section 144(b) of the MIPPA are sparse and that more time is needed to consider options for implementing these amendments to the statute. Other commenters had concerns that the program has not issued adequate guidance to implement these provisions.

Response: While we recognize that the regulatory changes established new requirements for oxygen suppliers after the 36 month payment cap, the statutory mandate for implementing the 36-month oxygen payment cap does not provide any flexibility for a delay in the implementation of this provision. In accordance with section 1834(a)(5) of the Act, as amended by section 5101(b) of the DRA, we are required to limit monthly payments to suppliers for oxygen equipment to 36 months of continuous use, effective January 1, 2006. Since implementation of the 36-month rental cap is required by section 5101(b) of the DRA, it is outside the scope of this rulemaking effort, which addresses implementation of section 144(b) of the MIPPA. Section 144(b) of the MIPPA amendments to section 1834(a)(5)(F) of the Act, repealing the transfer of ownership of oxygen equipment after the 36-month payment rental cap, were effective January 1, 2009. CMS was committed to meeting this statutory mandate. We note that sub-regulatory guidance was issued which provided additional details on implementing the provisions of section 144(b) of the MIPPA.

Comment: Many commenters disagree that the 36-month rental cap on oxygen and oxygen equipment applies to all equipment, accessories, and supplies used in conjunction with the oxygen equipment (other than the oxygen contents). They believe that separate payment should be allowed after the cap for replacement supplies and accessories such as cannulas, tubing, and regulators.

Response: As discussed in the above response, implementation of the 36-month rental payment cap for oxygen equipment was mandated by section 5101(b) of the DRA. The cap applies to both the monthly payment amount for oxygen and oxygen equipment and the portable equipment add-on payments. Since 1989, suppliers have been paid, in accordance with the rules set forth in section 1834(a)(5) of the Act and § 414.226 of our regulations, a monthly payment amount that includes payment for all equipment, accessories, supplies, and stationary and portable oxygen contents. The November 9, 2006 final rule (71 FR 65885) to implement section 5101(b) of the DRA provides additional discussion on the implementation of the oxygen 36-month rental payment cap. Section 1834(a)(5)(F) of the Act only authorizes payment for oxygen contents following the 36-month cap. These rules mandate continued payments for furnishing oxygen contents for use with

gaseous or liquid oxygen equipment after the cap. The statute does not authorize payment after the cap for accessories and supplies used with the oxygen equipment.

Comment: Two commenters suggested that the Congress repealed the provisions of the DRA requiring transfer of title for oxygen equipment to the beneficiary because the Congress realized that oxygen recipients need frequent services from suppliers. These commenters believe that the new regulatory changes did not address the number of oxygen service visits thereby permitting reductions in service visits and quality of care.

Response: In accordance with section 1834(a)(5)(F) of the Act, we have revised § 414.226(f)(1) to require a supplier who furnished oxygen equipment to a beneficiary during the 36th month of continuous use to continue furnishing the equipment for any period of medical need until the end of the reasonable useful lifetime established for the equipment. Section 1834(a)(5)(F) of the Act authorizes payments following the 36-month cap for oxygen contents. The statute does not authorize payment after the cap for services related to furnishing oxygen equipment other than maintenance and servicing of the equipment, which is addressed in section II.G.10.c. below in this section.

Comment: A number of commenters noted that accreditation standards require oxygen suppliers to have on-call availability 24 hours a day to respond to patient respiratory issues. However, without additional program reimbursement after the 36-month cap, these commenters believe that suppliers may not adequately comply with the accreditation requirement unless accreditation is addressed separately at § 414.226.

Response: This comment is outside the scope of the rule. The accreditation standards are required by Section 1834(a)(20) of the Act, as amended by Section 302 of the Medicare Prescripton Drug, Improvement, and Modernization Act of 2003 (MMA). Section 424.57(c)(22) requires compliance with accreditation as part of the DMEPOS supplier standards. Also, if a supplier is found to not meet a mandatory supplier standard such as accreditation requirements, we may invoke administrative remedies. In accordance with § 424.57(d), failure to meet a mandatory supplier standard may be addressed by revoking a supplier's billing privileges.

Comment: Several commenters indicated that we did not amend our regulations to include beneficiary safeguards to prevent oxygen suppliers, who do not want to provide services after the 36 month cap, from forcing more complex and costly oxygen patients into skilled nursing facilities or forcing beneficiaries to pay out-of-pocket for certain services.

Response: We appreciate the commenter's interest in the prevention of abuse to oxygen beneficiaries. We believe beneficiary safeguards for prevention of abuse when furnishing of oxygen and oxygen equipment are encompassed in the DMEPOS supplier standards. The supplier standard at § 424.57(c)(1) requires the supplier to operate its business and furnish Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements. Also, § 414.226(f) of our regulations requires that the supplier that furnishes oxygen equipment for the 36th continuous month during which payment is made must continue to furnish the equipment during any period of medical need for the remainder of the equipment's reasonable useful lifetime. The supplier may not charge the beneficiary or the program for services associated with meeting these requirements. Thus, if it is determined that the supplier is out of compliance with these requirements, CMS sanctions may apply.

As we discussed above, if a supplier is found to not meet a mandatory supplier standard, we may invoke administrative remedies. For example, in accordance with § 424.57(d), failure to meet a mandatory supplier standard may be addressed by revoking a supplier's billing privileges.

Comment: A number of commenters suggested amending our regulations to provide additional reimbursement after the 36-month cap when the oxygen supplier must assist beneficiaries due to power outages caused by natural disasters and other emergencies. Another commenter explained that an emergency could be defined as a beneficiary who is having trouble breathing after facing an unexpected environmental emergency situation.

Response: Section 1834(a)(5)(F) of the Act authorizes specific types of payments following the 36-month cap. The statute mandates continued payments for oxygen contents for use with gaseous or liquid oxygen equipment after the cap. Other than maintenance and servicing of the equipment, which is addressed in section II.G.10.c. below, the statute does not authorize other payment for services related to furnishing oxygen equipment. Thus, if a beneficiary's concentrator cannot function due to a power outage, the supplier may meet the beneficiary's oxygen needs by furnishing gaseous or liquid stationary equipment until the power resumes at the beneficiary's home. If oxygen equipment is lost or irreparably damaged due to an emergency situation such as a fire or flood, Medicare payment can be made for replacement of the oxygen equipment in accordance with § 414.210(f)(2).

Comment: Numerous commenters opposed the provisions in § 414.226(f)(1)(ii) and (f)(2)(ii) which requires the supplier to arrange to furnish oxygen equipment and oxygen if the beneficiary relocates to an area that is outside the normal service area of the supplier that initially furnished the equipment. Many commenters emphasized small and rural suppliers will have greater difficulty making arrangements outside their service area because these suppliers do not have expertise and resources to enter many arrangements outside their service area. Several commenters were concerned that supplier licensing and accreditation is not applicable outside their state or normal service area and this would present problems when supervising the furnishing of oxygen services for a beneficiary that relocates outside their service area. A few commenters noted that the costs associated with transferring a beneficiary to an out of area supplier were not discussed and thus a reasonable basis for the provisions at § 414.226(f)(1)(ii) and (f)(2)(ii) had not been established. One commenter contended that § 414.226(f)(2) is inconsistent with other regulations for the DME competitive bidding program.

Response: We understand there may be challenges with furnishing oxygen and oxygen equipment to traveling and relocating beneficiaries. However, in the CY 2009 PFS final rule with comment period (73 FR 69876), we explained that the provisions of section 144(b) of the MIPPA do not contain exceptions to the 36 month rental cap for situations when a beneficiary travels or permanently relocates to another area. In instances in which a beneficiary relocates outside of the normal service area of a supplier, the current supplier must make arrangements in the new service area with a Medicare-enrolled supplier who is required to be compliant with all applicable Federal and State licensure and regulatory requirements. Furthermore, we have worked with our contractors who issued subregulatory guidance on billing for situations when a beneficiary travels or permanently relocates because these situations necessitate attention to the date of service and location of the supplier. We

will continue to monitor this issue and if necessary, develop additional subregulatory instructions. Concerns related to the regulations for the DMEPOS competitive bidding program are not in the scope of these regulatory changes.

Comment: Some commenters noted that beneficiaries that have not reached the end of the 36-month cap may confront difficulties in securing a new supplier in an area that is outside the normal service area of the supplier that initially furnished the equipment since the new supplier will receive a reduced number of payments before the end of the 36-month rental period. Several commenters requested confirmation that § 414.226(g) does not require that the supplier furnish or make arrangements to furnish oxygen to a beneficiary outside of the service area during the 36-month rental period.

Response: Regulatory changes concerning the 36-month rental cap are outside the scope of this rule which is intended to implement the provisions of section 144(b) of the MIPPA. As a result, we are finalizing § 414.226(f)(1)(ii) and (f)(2)(ii) as proposed.

However, as discussed in our response above, we have worked with our contractors who issued subregulatory guidance on billing for situations when a beneficiary travels or permanently relocates because these situations necessitate attention to the date of service and location of the supplier. When a beneficiary travels or relocates during the 36-month rental period, the existing supplier can aid the beneficiary in locating a supplier in the new service area. In addition, ombudsman staff at 1–800–Medicare has been trained to assist beneficiaries in these situations to find a new supplier. We will continue to monitor this issue closely and will take appropriate actions to address these situations.

Comment: Several commenters requested clarification on how to apply the § 414.230 requirement of continuous use for durable medical equipment to the 36-month rental cap for oxygen equipment.

Response: In the CY 2009 PFS final rule with comment period (73 FR 69937), we added § 414.230(h) to our regulation on determining a period of continuous use to clarify that after the 36-month rental period, a new period of continuous use does not begin under any circumstance in the case of oxygen equipment furnished between the end of the 36-month rental cap and the end of the equipment's reasonable useful lifetime. The statute and regulation require a supplier to continue furnishing the oxygen equipment after the 36th continuous month for any period of medical need for the remainder of the equipment's reasonable useful lifetime. Additional details pertaining to the definition of continuous use of oxygen and oxygen equipment both before and after the 36-month rental cap have been issued through sub-regulatory guidance as part of the implementation of the 36-month rental cap mandated by the DRA. In addition to transmittal 421 (Change Request 6297), we provided program guidance on January 26, 2009 to contractors containing oxygen and oxygen equipment continuous use policies. These policies have been posted on the contractors' Web sites.

Comment: Several commenters requested clarification on supporting documentation for replacement oxygen equipment after the expiration of the 5-year useful lifetime.

Response: When oxygen equipment is replaced because the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime, a new Certificate of Medical Necessity (CMN) is required to establish a new 36-month rental period and new reasonable useful lifetime. Suppliers must also furnish documentation in order to verify that the equipment being replaced has been in use for at least 5 years. Additional details pertaining to the documentation required to support the replacement of oxygen equipment after the expiration of the 5-year reasonable useful lifetime have been issued through Medicare contractor subregulatory guidance which has been posted on the contractor's Web sites.

Comment: Several commenters suggested that the requirements at § 414.226(f)(1)(i) and (f)(2)(i) for a supplier to continue furnishing oxygen and oxygen equipment after the cap prevent a beneficiary from changing suppliers if the supplier is performing poorly. This potentially results in the beneficiary being forced to utilize a low quality supplier for at least 5 years.

Response: Section 144(b) of the MIPPA requires that the supplier furnishing equipment in the 36th continuous month continue furnishing the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment, as determined by the Secretary. We believe the language of section 1834(a)(5)(F) of the Act, as amended by 144(b) of the MIPPA, is clear. Since oxygen contents are furnished as part of the continued furnishing of gaseous or liquid oxygen equipment, this requirement extends to oxygen contents furnished after the cap. This is explained in more detail in section II.G.10.b below. Regarding the quality of items and services provided by suppliers of oxygen and oxygen equipment, beneficiaries who encounter such problems should report them by contacting 1–800–Medicare. A beneficiary ombudsman will work to resolve the issue. Also, we note that program requirements are now in place and require suppliers of oxygen and oxygen equipment to have surety bonds and be accredited to meet mandated quality standards. Failures to remain in compliance with these quality standards will be reported to the supplier's accreditation organization.

Comment: Several commenters requested clarification on changing oxygen equipment systems during and after the oxygen rental period.

Response: During and after the 36-month rental period, if the beneficiary's physician orders a change in modality (oxygen equipment delivery system), the supplier must furnish that new modality without a restart of the 36-month rental period per the continuous use regulations at § 414.230. Section 414.226(g)(2) prohibits a supplier from changing a beneficiary's oxygen equipment/modality during the 36 month payment period without a physician's order, unless the equipment is lost, stolen, irreparably damaged, or in cases where the beneficiary elects to upgrade to newer technology equipment. Also, § 414.226(g)(1) requires that the supplier that furnished oxygen equipment for the first month during which payment is made must continue to furnish the equipment for the entire 36-month period unless certain specific exeptions apply.

After consideration of the public comments, we are finalizing these provisions without modification.

b. Payment for Oxygen Contents After the Rental Cap

Section 144(b)(1) of the MIPPA amends section 1834(a)(5)(F)(ii)(II) of the Act and requires us to continue to make payments to suppliers for furnishing oxygen contents after the 36-month rental cap for oxygen equipment ends. Under this provision, an oxygen supplier that furnished liquid or gaseous oxygen equipment during the 36-month rental period, and is required by section 1834(a)(5)(F)(ii)(I) of the Act to continue furnishing the equipment after the 36-month rental period ends, will receive payment for furnishing oxygen contents necessary for use with liquid or gaseous oxygen equipment after the 36-month rental period. Section 1834(a)(5)(F)(ii)(II) of the Act establishes the payment amount for the

oxygen contents as that set forth in section 1834(a)(9) of the Act.

We revised § 414.226(d) and (f) to specify that payment shall be made for oxygen contents for use with supplier-owned liquid or gaseous oxygen equipment furnished after the 36-month rental period. An oxygen supplier that furnishes liquid or gaseous oxygen equipment during the 36-month rental month must continue to furnish the oxygen contents for any period of medical need for the remainder of the reasonable useful lifetime of the liquid or gaseous oxygen equipment established in accordance with § 414.210(f)(1). This requirement is necessary because liquid and gaseous oxygen systems (stationary and portable) require on-going delivery of oxygen contents in tanks or cylinders to furnish oxygen to the patient. We believe that the MIPPA provisions when read together provide that the supplier that continues to furnish liquid or gaseous oxygen equipment in accordance with section 1834(a)(5)(F)(ii)(I) of the Act is also required to furnish the oxygen contents housed in those tanks. This is based on the nature of the benfit and the requirement in the statute that the supplier ''must continue to furnish'' the equipment during any period of medical need. Empty tanks furnished in accordance with section 1834(a)(5)(F)(ii)(I) of the Act would provide no benefit to the patient, since the patient would not be receiving oxygen through the equipment.

We revised § 414.226(f) to specify that the supplier must make arrangements for the beneficiary to continue receiving the equipment if the beneficiary relocates at some time after the 36-month rental period but before the end of the reasonable useful lifetime of the equipment. Likewise, we revised § 414.226(f) to specify that, in the case of liquid or gaseous equipment (stationary and portable) the supplier must make arrangements for the beneficiary to continue receiving oxygen contents if the beneficiary relocates at some time after the 36-month rental period but before the end of the reasonable useful lifetime of the liquid or gaseous equipment (stationary and portable). The supplier must make arrangements for the beneficiary to continue receiving the oxygen contents and equipment at his or her new residence.

Comment: One commenter noted the rule does not specify if Medicare pays for the delivery of oxygen contents when the beneficiary elects to purchase their oxygen equipment.

Response: In accordance with § 414.226(d)(3)(i) and § 414.226(d)(4)(i), payment is made for the delivery of oxygen contents used with beneficiary-owned equipment as long as such contents are medically necessary.

Comment: Several commenters questioned the billing instructions for oxygen contents with regards to HCPCS codes, supporting documentation, and units of service.

Response: Since the publication of the CY 2009 PFS final rule with comment period, we have released subregulatory instructions on these issues for oxygen and oxygen equipment. The contents of these instructions have been posted on the contractors' Web sites.

Comment: Some commenters requested increased payments for higher contents usage. One commenter stated that after the 36 month cap, individual patient usage may increase due to a change in patient condition requiring more oxygen contents. The commenters suggested the supplier should be permitted to issue an Advanced Beneficiary Notice (ABN) and bill the beneficiary for nonassigned claims.

Response: Section 144(b)(1) of MIPPA, which amends section 1834(a)(5)(F)(ii) of the Act, does not provide for additional payments for volume adjustments on content payments after the 36-month rental cap. The monthly payments for oxygen contents include payment for oxygen contents needed for the entire month. The payment amount does not vary depending on the quantity (low or high) of oxygen needed. Use of an ABN is therefore not appropriate in these situations.

Comment: One commenter requested clarification on whether a nonparticipating DME supplier who has accepted assignment of claims for oxygen and oxygen equipment during the 36-month rental cap period has to continue to accept assignment of claims for oxygen contents furnished after the 36-month cap.

Response: Since nonparticipating suppliers can elect to accept assignment on a claim by claim basis, a non-participating supplier can decide to provide oxygen contents on an unassigned basis after the 36-month payment cap.

After consideration of the comments received, we are adopting these provisions as final without modifications.

c. Maintenance and Servicing of Supplier-Owned Oxygen Equipment After the Rental Cap

Section 1834(a)(5)(F)(ii)(III), as amended by section 144(b)(1) of the MIPPA, authorizes payment for maintenance and servicing of supplier-owned oxygen equipment furnished after the 36-month rental period if we determine such payments are reasonable and necessary.

In the CY 2009 PFS final rule with comment period, we determined that it is not reasonable and necessary to pay for servicing (repair) and non-routine maintenance of supplier-owned oxygen equipment. Given that the supplier owns the equipment, we believe the supplier should be responsible for maintaining its equipment in working order as it did during the 36-month rental period. In addition, warranties covering 5 years are generally available for the top selling brands of oxygen equipment and as discussed in the November 9, 2006 final rule (71 FR 65917) and the CY 2009 PFS final rule with comment period (73 FR 69878), we understand from manufacturers that such products are generally dependable. In a September 2006 report entitled ''Medicare Home Oxygen Equipment: Cost and Servicing,'' (OEI–09–04–00420), the Office of Inspector General (OIG) of the Department of Health and Human Services found that only 22 percent of beneficiaries who began renting oxygen equipment in 2001 rented the equipment for 36 months or longer. Recent claims data analysis indicates that more than 75 percent of Medicare beneficiaries do not rent oxygen equipment for longer than the 36 months (see Table 52 in section XIII. of this final rule with comment period.) Therefore, oxygen equipment is returned to suppliers before the end of the 36-month rental period in more than 75 percent of cases, and suppliers are then able to furnish the equipment to other beneficiaries, starting new 36-month periods of rental payments for the same equipment. Given that equipment that is less than 5 years old requires minimal maintenance and servicing, and in more than 75 percent of oxygen equipment rental episodes, suppliers receive more than 36 rental payments for the same piece of equipment, we concluded that suppliers should be responsible for maintaining their equipment in working order after the 36-month rental period as they did during the 36-month rental period.

Although we determined as part of the CY 2009 PFS final rule with comment period provisions that it is not reasonable and necessary to make payments for repair or non-routine maintenance of the supplier-owned oxygen equipment, we made an initial determination applicable to CY 2009 only that it is reasonable and necessary for the safety of the beneficiary to make

payments for periodic, in-home visits by suppliers to inspect oxygen concentrators and transfilling equipment and provide routine maintenance and servicing during these visits to ensure that the equipment is functioning properly. Therefore, we revised § 414.210(e)(2), to provide payment in 2009 for general maintenance and servicing of supplier-owned oxygen concentrators and transfilling equipment furnished after the 36-month rental period in accordance with section 1834(a)(5)(F)(ii)(I) of the Act consistent with our authority in section 1834(a)(5)(F)(ii)(III) of the Act. Payments are made in 2009 when the supplier performs routine maintenance and servicing as part of a visit to the beneficiary's home, 6 months after the 36-month rental period ends. Payments in 2009 for a maintenance and service visit may be made when the beneficiary is at home or at a temporary residence (for example, a vacation residence). For each visit, payment is equal to the Medicare allowed payment amount for 30 minutes of labor associated with repair of beneficiary-owned DME. As we indicated in the November 9, 2006 final rule for implementing section 5101(b) of the DRA (71 FR 65917), we believe that payment for 30 minutes of labor will adequately compensate suppliers for general maintenance and servicing visits based on findings by the OIG in their September 2006 report (OEI–09–04–00420) that many routine maintenance activities performed by suppliers on concentrators could be performed within that timeframe.

Separate payment is not made for parts replaced during the general maintenance and servicing visit, as the primary purpose of the periodic visit is to check the supplier-owned equipment to ensure that it is functioning properly. If parts need to be replaced in order to make the equipment serviceable, we concluded that the supplier should be responsible for replacing the parts on equipment from their inventory that they are furnishing to the beneficiary in order to meet the beneficiary's medical need for oxygen.

We solicited comments from interested parties on whether these payments should continue past CY 2009. The following is a summary of the comments we received and our responses.

Comment: Numerous commenters were in favor of continuing payment for maintenance and servicing visits past 2009. However, many commenters stated that a biannual maintenance and servicing payment is insufficient in frequency. Other commenters suggested that limiting maintenance and servicing payments to visits every 6 months will result in patients being hospitalized due to respiratory conditions. The commenters suggested that more frequent maintenance and servicing visits will prevent hospitalizations. Commenters also opposed basing the payment amount for maintenance and servicing on 30 minutes of labor. These commenters felt that the payment amount of two units of labor was inadequate to cover travel, labor (average 2 to 4 hours for travel and visit time), repairs, and supplies for a home visit. Several commenters requested clarification on the specific timeframe for when a maintenance and servicing visit may occur after the end of the 36-month rental period. Several commenters requested that we provide more specific data and the methodology used to compute the reimbursement for a maintenance and servicing visit.

A number of commenters suggested that the maintenance and servicing rules and payments for oxygen equipment should be similar to those described at § 414.229(e) for capped rental items furnished prior to January 1, 2006. Under these rules, the maintenance and servicing payment amounts are made every 6 months, beginning 6 months after the end of the rental cap period and cover all maintenance, servicing, and repair of the equipment that is needed after the rental cap. The payment amounts are limited to one month's rental payment for the item.

Response: We appreciate the comments received and agree that continuing maintenance and servicing payments for oxygen concentrators and transfilling equipment past 2009 is reasonable and necessary for the safety of the beneficiary. We are also clarifying that the supplier that furnishes the equipment during the 36th continuous month during which payment is made is responsible for continuing to furnish the equipment after the 36th continuous month (after the cap) and is responsible for furnishing equipment in good working order regardless of the implementation of section 1834(a)(5)(F)(ii)(III) of the Act. We would like to stress this point for commenters who suggest that beneficiaries will be harmed unless these payments are sufficient to cover specific costs incurred by the supplier for maintaining and servicing supplier-owned equipment.

Nevertheless, we agree with commenters that it is reasonable and necessary to increase the maintenance and servicing payment established for 2009 to further ensure the equipment is maintained and serviced by the supplier, thereby protecting beneficiaries who rely on oxygen equipment to deliver a sufficient concentration and quantity of oxygen on an uninterrupted basis. We also agree with commenters who believe that it is reasonable and necessary to establish rules for maintenance and servicing of certain oxygen equipment that are similar to the rules described at § 414.229(e) for capped rental items furnished to beneficiaries beginning on or before December 31, 2005.

These rules allow payment every 6 months, beginning 6 months after the end of the rental cap period, for all necessary maintenance and servicing. In accordance with § 414.229(e), a reasonable fee is established for maintenance and servicing not to exceed 10 percent of the purchase price of the item. Our experience and an OIG report from June 2002 entitled ''Medicare Maintenance Payments for Capped Rental Equipment'' (OEI–03–00–00410) indicates that such rules more than adequately reimbursed suppliers for maintenance and servicing of capped rental items. In addition, we believe it is necessary to continue requiring that suppliers make visits every 6 months to the beneficiary's home to inspect the oxygen equipment to ensure that all of the equipment maintenance and servicing needs are being addressed.

Regarding the fee for maintenance and servicing, in order to model the payment for maintenance and servicing of certain oxygen equipment after the capped rental maintenance and servicing provision at § 414.229(e), it is necessary to develop maintenance and servicing payments for oxygen equipment in a way that ensures that the amount does not exceed 10 percent of the purchase price of the equipment. The monthly payment amount for oxygen and oxygen equipment includes payment for oxygen contents in addition to equipment rental and is not established based on a percentage of the purchase price of the equipment, as is the case for capped rental items. In the September 2006 report on oxygen equipment, the OIG found that the average cost of an oxygen concentrator was $587. Increasing this amount to a 2010 price based on the percentage change in the Consumer Price Index for all Urban Consumers (CPI–U) from 2006 to 2010 yields a purchase price of $660. We note that the percentage change in the CPI–U from June 2008 to June 2009, the factor used to inflate prices from 2009 to 2010, is a negative 1.41 percent. Therefore, we use a factor of zero percent as the indicator for inflation for this year. Establishing the maintenance

and servicing fee based on 10 percent of this average price would result in a payment of $66 for CY 2010. For subsequent years, the payment amount will be adjusted based on the covered item update for DME as set forth in section 1834(a)(14) of the Act.

After careful consideration of comments on this issue, we are adding § 414.210(e)(5) to make ongoing maintenance and servicing payments for oxygen concentrators and transfilling equipment (or equipment other than stationary or portable gaseous or liquid oxygen equipment) furnished on or after July 1, 2010 based on a reasonable fee not to exceed 10 percent of the purchase price for a stationary oxygen concentrator. We are making these changes effective for items furnished on or after July 1, 2010, to allow time for necessary systems changes. We are revising § 414.210(e)(2) to continue the maintenance and servicing policy established for certain oxygen equipment for 2009, for items furnished from January 1, 2010 through June 30, 2010. For items furnished on or after July 1, 2010, the maintenance and servicing payments would be made following each subsequent 6-month period until either medical necessity ends or the beneficiary elects to obtain new equipment. Only one maintenance and servicing payment will be made during each 6-month period for any combination of concentrator and oxygen transfilling equipment used by the beneficiary in their home. The maintenance and servicing payment includes payment for all necessary maintenance and servicing of the beneficiary's oxygen concentrator (stationary or portable) and transfilling equipment and a minimum of one required visit to the beneficiary's home to inspect the equipment. Consistent with our existing policy, no payment is made for maintenance and servicing of gaseous or liquid oxygen equipment. Finally, in response to comments, we are revising § 414.210(e)(2), and adding (e)(2)(iii) and (e)(5)(iv) to clarify that the visit to the beneficiary's home must occur during the first month of the 6-month period. This will ensure that the visits occur in 6-month intervals so that maintenance and servicing necessary to keep the equipment in good working order for the next 6 months is performed for each subsequent 6-month period and avoids overlap of 6-month maintenance and servicing episodes.

Comment: One commenter asked for clarification as to whether suppliers can enter into a service contract with the beneficiary after the 36-month cap for additional maintenance and service visits along with any necessary on-call visits.

Response: In accordance with 1834(a)(5)(F)(ii)(I) of the Act and regulations at § 414.226(f)(1), the supplier is responsible for furnishing, or making arrangements to furnish, the oxygen equipment in good working order for any period of medical need after the 36-month cap for the remainder of the reasonable useful lifetime of the equipment. In addition, as indicated above, we are revising § 414.210(e)(2) and § 414.210(e)(5) to make payment for ongoing maintenance and servicing of equipment other than gaseous or liquid oxygen equipment after the cap. Therefore, we believe it would be inconsistent with these provisions for suppliers to require that beneficiaries enter into service contracts for maintenance and servicing of rented oxygen equipment at any time or to charge the beneficiary for maintenance and servicing of equipment beyond those allowed by regulations at § 414.210(e). As explained previously, the supplier is required to furnish gaseous or liquid oxygen equipment in good working order during the 36-month rental period and following the 36-month rental period when payments continue for delivery of oxygen contents. Therefore, it would be inconsistent with these provisions for the supplier to charge the beneficiary for maintenance and servicing of gaseous or liquid oxygen equipment.

After consideration of the comments received, we are adopting as final § 414.210 by revising § 414.210(e)(2) and adding § 414.210(e)(5).

d. Other Public Comments Received on the CY 2009 PFS Final Rule With Comment Period

Comment: Several commenters noted that CMS did not discuss the application of policies for Advanced Beneficiary Notices (ABN) on the period following the 36-month oxygen payment cap.

Response: Using an ABN in the post 36-month period is only applicable when upgrading to medically unnecessary equipment or equipment with features that are not medically necessary. As a result, we do not anticipate frequent application of an ABN during the post 36-month period and did not incorporate this issue in our regulations at § 414.226(f) and (g).

Comment: Several commenters explained that currently respiratory therapists are not separately reimbursed as licensed practitioners under the PFS. As a result, they receive payment for their professional services from suppliers receiving payment for furnishing oxygen equipment. Thus, reductions in payment for home oxygen equipment will adversely affect payments for respiratory therapists. The commenters requested that payment should be established for respiratory therapists under the PFS.

Response: This topic of Medicare coverage and payment for the professional services of licensed respiratory therapists is not a subject of the CY 2009 PFS final rule with comment period or this final rule with comment period for implementation of section 144(b) of MIPPA and therefore outside the scope of this rule.

Comment: Several commenters raised concern that our regulations do not address situations where an oxygen supplier discontinues its business or declares bankruptcy. The commenters believe a new supplier will refrain from accepting patients from a terminating supplier because the new supplier will receive fewer monthly rental payments and upon reaching the payment cap, the new supplier must continue furnishing the oxygen and oxygen equipment for the remainder of the reasonable useful lifetime of the equipment.

Response: We will evaluate current regulations to determine if oxygen equipment that is lost due to bankruptcy can be replaced. We are not addressing bankruptcy in this rulemaking which is intended to address the provisions of section 144(b) of the MIPPA.

Comment: Several commenters objected that our regulation at § 414.210(f)(1) establishes that the reasonable useful lifetime of DME cannot be less than 5 years and instead recommended that the regulation be revised for oxygen equipment to 3 years. One commenter stated most oxygen compressors expire after approximately 9,000 to 10,000 hours of use of the equipment. Additionally, one commenter requested clarification on whether the useful lifetime restarts if the oxygen equipment has been changed or replaced after the equipment was originally delivered to the patient but before the expiration of 5 years.

Response: The reasonable useful lifetime begins with the initial delivery date of the equipment. Equipment can be changed for another oxygen modality or replaced without affecting the duration of the reasonable useful lifetime as long as there is not a break in the medical necessity of oxygen (break in need) during the 36-month rental period, for at least 60 days plus the days remaining in the last paid rental month. It is important to note, however, that our regulations did not propose an amendment to § 414.210(f)(1) and as such, revisions to

the length of the reasonable period are outside the scope of this rulemaking effort.

11. Section 152(b): Coverage of Kidney Disease Patient Education Services

Section 152(b) of the MIPPA provides for coverage of kidney disease education (KDE) services for patients. The following is an outline of our final rule to implement the statutory amendments.

a. Statutory Authority

Section 152(b) of the MIPPA amended section 1861(s)(2) of the Act by adding a new subparagraph (EE) ''kidney disease education services'' as a Medicare-covered benefit under Part B. This new benefit is available for Medicare beneficiaries diagnosed with Stage IV CKD, who in accordance with accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant. KDE services will be designed to provide comprehensive information regarding:

- The management of comorbidities, including delaying the need for dialysis;
- Prevention of uremic complications;
- Options for renal replacement therapy (including hemodialysis and peritoneal dialysis, at home and in-center, as well as vascular access options and transplantation);
- Ensuring that the beneficiary has the opportunity to actively participate in his or her choice of therapy; and
- Tailored to meet the needs of the beneficiary involved.

b. Public Meetings

Section 1861(ggg)(3), as added by section 152(b) of the MIPPA, requires that the Secretary set standards for the content of the KDE services after consulting with various stakeholders, who to the extent possible, had not received industry funding from a drug or biological manufacturer or dialysis facility. On November 6, 2008, and December 16, 2008, we held two feedback sessions to solicit stakeholder comments regarding the implementation of section 152(b) of the MIPPA. Both feedback sessions were open to the public. In addition to the feedback sessions, we conducted an internal review of the available medical evidence, literature, and currently available CKD patient education programs. Transcripts from both events are available on the CMS Web site at *http://www.cms.hhs.gov/CoverageGenInfo/08_CKD.asp#TopOfPage.* A summary of the feedback sessions is available in the proposed rule (74 FR 33615 through 33616).

c. Summary of Proposed Rule and Comments

We proposed, consistent with section 1861(ggg) of the Act, to amend 42 CFR part 410 to add new § 410.48 for KDE services as a Medicare Part B benefit. The following is a summary of the provisions of the proposed rule, and the comments we received on the proposed rule, and the changes we are making in this final rule regarding coverage of KDE under section 152(b) of the MIPPA. We received broad support from commenters regarding the addition of KDE services as a Medicare Part B covered benefit. Most were generally pleased with the proposed rule and commended us for our expeditious implementation of the MIPPA provisions. Commenters appreciated that CMS collected and incorporated broad stakeholder feedback in the development of the proposed rule.

(1) Definitions (§ 410.48(a))

As related to the implementation of section 1861(ggg) of the Act, we proposed the following definitions in § 410.48:

- Kidney Disease Patient Education Services: Consistent with section 1861(ggg)(1) of the Act, we defined Kidney Disease Patient Education Services as face-to-face educational services provided to patients with stage IV CKD. We specified that KDE services are provided in a face-to-face manner based on stakeholder feedback received during the consultation meetings and our general rulemaking authority. Face-to-face education is consistent with sections 1861(ggg)(C)(ii) and (iii) of the Act, which provide that the services should be designed to ensure that the beneficiary has the opportunity to actively participate in the choice of therapy and be tailored to meet the needs of the beneficiary involved.

Comment: One commenter agreed with our proposal to define KDE as face-to-face educational services provided to patients with Stage IV CKD. Several commenters asked us to consider allowing the services to be provided via telehealth and in Federally qualified health centers (FQHCs), since multiple education sessions may be difficult for some patients due to transportation issues and recommended that KDE services be added to the telehealth services at § 410.78. One commenter stated that we have recognized telehealth as a ''face-to-face'' encounter in the past.

Response: We appreciate the concerns raised by commenters regarding access to services in rural areas. In the proposed rule, we specified that KDE services be provided in a face-to-face manner based on stakeholder feedback received during the consultation meetings and our general rulemaking authority. Face-to-face education is consistent with sections 1861(ggg)(C)(ii) and (iii) of the Act, which provide that the services should be designed to ensure that the beneficiary has the opportunity to actively participate in the choice of therapy and be tailored to meet the needs of the beneficiary involved.

At this time, we believe that it would be more appropriate to consider the addition of KDE services for telehealth through full notice and comment procedures in the CY 2011 PFS proposed rule, based on the experience we gain observing the KDE programs over 1 year. We will accept requests for consideration to add KDE services to the list of approved telehealth services in the CY 2011 PFS proposed rule if received prior to December 31, 2009. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, visit our Web site at *http://www.cms.hhs.gov/telehealth/.*

Comment: One commenter stated that qualified persons should be precluded from using videos as a method for providing KDE services since patients need to ask questions and may fall asleep during a video due to their illness and anemia levels.

Response: We received similar feedback from stakeholders during the feedback sessions and understand the commenter's concerns about using videos as a method for providing KDE services. We agree that a video is not an appropriate modality for providing KDE services, which is why we specify that KDE services are services provided in a face-to-face manner.

We are retaining the definition of Kidney Disease Patient Education Services as proposed in this final rule.

- Physician: For purposes of KDE services, we proposed to define physician using the definition in section 1861(r)(1) of the Act; it defines ''physician'' as ''a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs such function or action (including a physician within the meaning of section 1101(a)(7) [of the Act].'' We received no comments regarding our proposed definition of physician and are adopting this definition in this final rule.
- Qualified Person: Consistent with section 1861(ggg)(2)(A) of the Act, for purposes of KDE services, we proposed to define a ''qualified person'' as a

physician (as defined in section 1861(r)(1) of the Act); a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) (as defined in section 1861(aa)(5) of the Act, and implemented in § 410.74, § 410.75, and § 410.76 of this subpart). A provider of services located in a rural area is also included in the statute's definition of a qualified person. Section 1861(u) of the Act defines ''provider of services'' to be ''a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program or, for purposes of sections 1814(g)and section 1835(e) [of the Act], a fund''. We define a ''qualified person'' to include a provider of services located in a rural area and would include each of these healthcare entities except for a ''fund.''

In order for a provider of services to be a ''qualified person,'' the entity must be located in a rural area. We include in the definition of a ''qualified person'', only those hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and hospice programs that are located in a rural area under section 1886(d)(2)(D) of the Act (as defined in our regulations at § 412.64(b)(ii)(C)) and include hospitals and CAHs that are reclassified from urban to rural status pursuant to section 1886(d)(8)(E) of the Act, as defined in § 412.103. Specifically, § 412.64(b)(ii)(C) defines ''rural'' to mean any area outside an urban area, which § 412.64(b)(ii)(A) defines as a metropolitan statistical area (MSA) as defined by the President's Office of Management and Budget (OMB). Therefore, we believe that a hospital, CAH, SNF, CORF, HHA, or hospice program that is not physically located in an MSA should be considered ''rural'' for this benefit.

Section 1886(d)(8)(E) of the Act, implemented in § 412.103, requires us to treat hospitals that meet specified criteria as geographically rural under section 1886(d)(2)(D) of the Act even though they are physically located in an MSA. Because the statute identifies these hospitals as rural, we believe that it is appropriate to consider these hospitals as qualified persons for purposes of the KDE benefit.

Comment: Several commenters requested that we consider adding various other healthcare professionals to the definition of a qualified person including registered dietitians, renal dieticians, licensed dieticians, nutrition support clinicians (nutrition support physician, nurse, or pharmacist), medical nutrition therapists, nephrology social workers, registered nurses, nephrology nurses, and/or transplant coordinators as qualified persons or as members of a multi-disciplinary team headed by the qualified person to provide KDE services. One commenter was concerned that dietary advice provided by physicians, nurses, and NPs, while well meaning, is often overly restrictive, and could lead to malnutrition and lower quality of life. One commenter requested that at least one of the sessions be designated for the patient to meet with a registered dietitian. One commenter stated that a dietitian who is board certified in renal adds additional competency to his or her qualifications to provide KDE services.

Response: The Congress did not specifically authorize the Secretary to approve additional healthcare professionals within this defined term. Therefore, we are not accepting the comments to further expand the definition to include other healthcare professionals.

Comment: Regarding providers of services located in rural areas, one commenter recommended that we rely on facilities to schedule the appropriate staff to teach KDE services in these facilities and not to narrow the clinical practice activities beyond those permitted within each state's clinical scope of practice laws.

Response: Providers of services are responsible for providing proper staffing of KDE services. We encourage facilities to review the standards for content of KDE services when determining who will be providing such services, similar to how a facility would choose the appropriate staff for other facility functions.

Comment: One commenter disagreed with our proposed definition of a provider of services located in a rural area as a ''qualified person'' who may be paid for kidney disease education services. The commenter believes that the definition of a provider of services in a rural area should include rural hospital-based dialysis facilities. The commenter stated that these types of facilities are the only dialysis facilities that could be interpreted as a qualified person under section 1861(ggg)(2)(A)(i) of the Act and that renal dialysis facilities not located within a hospital are not providers of services under 1861(ggg)(2)(B). Furthermore, the commenter indicated that, as a practical matter, hospital-based dialysis facilities in rural areas are the only providers of services that would be capable of providing kidney disease education services as the Congress intended under the provisions of MIPAA.

Response: We disagree with the commenter's request to include dialysis facilities within the definition of a ''provider of services located in a rural area.'' Section 1861 (ggg)(2)(B) of the Act explicitly excludes renal dialysis facilities from being ''qualified persons'' for purposes of the kidney disease education benefit. The statute does not provide an exception for dialysis facilities located within hospitals. We do not consider dialysis facilities located in a hospital to be different from a freestanding dialysis facility for purposes of the statutory exclusion.

In addition, section 1861(u) of the Act defines a provider of services to be a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice. The provisions of MIPAA require that the provider of services must be located in a rural area in order to furnish KDE services. In implementing the KDE benefit, to exclude these providers of services located within a rural area would be contrary to the statutory definition of the term ''provider of services.''

Therefore, in this final rule with comment period and as specified in the statutory definition of a ''qualified person,'' we consider a qualified person to be either a physician (as defined in section 1861 (r)(1) of the Act) or a PA, NP, or CNS; or a provider of services located in a rural area, which includes a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice. A qualified person under this benefit does not include a renal dialysis facility, whether freestanding or hospital-based, regardless of whether the renal dialysis facility is located in a rural area or not. While the hospital-based renal dialysis facility located in a rural area is not a ''qualified person'' for purposes of payment for KDE services, we note that the hospital of which the hospital-based renal dialysis facility is a part would meet the definition of a ''qualified person'' because it is in a rural area.

- Renal Dialysis Facility: The Congress has provided in section 1861(ggg)(2)(B) of the Act that a ''renal dialysis facility'' may not be a ''qualified person.'' We proposed to define this term, consistent with § 405.2102 of this title, as ''a unit which is approved to furnish dialysis services(s) directly to ESRD patients.'' We received no comments on the definition and are adopting the proposed definition in this final rule.

• Stage IV Chronic Kidney Disease: Section 1861(ggg)(1)(A) of the Act states that KDE services shall be furnished to beneficiaries diagnosed with Stage IV CKD, who according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant. Based on stakeholder feedback, we proposed to define Stage IV CKD as kidney damage with a severe decrease in GFR quantitatively defined by a GFR value of 15–29 ml/min/1.73 m^2, using the Modification of Diet in Renal Disease (MDRD) Study formula.[1] Because there are currently no agreed upon accepted clinical guidelines that describe the stage IV patients who would eventually require dialysis or a kidney transplant, we proposed to cover all stage IV patients. We received no comments regarding our proposed definition of Stage IV CKD or regarding clinical guidelines for identifying beneficiaries with stage IV CKD that will require dialysis or a kidney transplant. Therefore, we are adopting our proposed definition of Stage IV CKD in this final rule.

(2) Covered Beneficiaries (§ 410.48(b))

Consistent with section 1861(ggg)(1)(A) of the Act, we proposed that Medicare beneficiaries are eligible to receive KDE services if the beneficiaries are diagnosed with Stage IV CKD (as defined in new § 410.48(a)), and have been referred for such services by the physician managing the beneficiary's kidney condition.

Comment: Some commenters recommended that we modify the provisions regarding beneficiaries eligible to receive KDE services to indicate that the beneficiary be diagnosed with at least stage IV CKD. Several commenters held the opinion that the Congress envisioned that defining stage IV CKD would not be a precise process by requiring that CMS rely upon accepted clinical guidelines. Commenters were also of the opinion that the Congress recognized that some beneficiaries should qualify for the benefit because they were at a stage where RRT was imminent, but had not commenced. Commenters believed that the Congress added a limiting clause that precludes beneficiaries who are on dialysis or have received a transplant, which would prevent more than the targeted population from obtaining these services. Several commenters pointed out that the KDOQI guidelines acknowledge that the GFR ranges/measurements established in the guidelines should not be used as definitive cut-offs between stages because using such cut-offs is inherently arbitrary. Commenters requested that CMS not adopt a ridged approach, but rather recognize that beneficiaries with stage IV and those beneficiaries with stage V that have not yet started renal replacement therapy should be treated similarly for purposes of qualifying for the KDE services.

Response: We understand and appreciate that the staging criteria is a classification system and understand the commenters' desire for beneficiaries to have access to this important benefit. However, there is no statutory authority to expand eligibility for individuals beyond those noted in the proposed rule.

Comment: One commenter asked that we consider the needs of adolescent/young adult renal transplant patients between 18 and 24 years old that are transitioning from pediatric to adult nephrology care.

Response: We appreciate that adolescents and young adults with CKD have unique needs that need to be addressed as part of their overall plan of care. The standards for content allow for the KDE services to be tailored to the needs of the beneficiary involved. We note that an adolescent/young adult described by the commenter would need to be a Medicare beneficiary and meet the eligibility provisions of this rule in order to obtain services under this benefit.

Comment: One commenter requested that we use a standardized method to screen qualifying beneficiaries to participate in the KDE services.

Response: We are defining stage IV CKD as ''kidney damage with a severe decrease in glomerular filtration rate (GFR) quantitatively defined by a GFR value of 15–29 ml/min/1.73m^2, using the MDRD Study formula,'' and required that the beneficiary obtain a referral from the physician managing the beneficiary's kidney condition. These provisions provide a standardized method for determining if a beneficiary is eligible for KDE services.

Comment: Some commenters indicated that referrals for KDE services should not be limited to just those obtained from the physician managing the beneficiary's kidney condition. Commenters suggested that we allow referrals from those that meet the definition of a qualified person since many CKD patients are not under the care of a single physician managing the beneficiary's kidney condition. Commenters were concerned that a physician who diagnoses the beneficiary with CKD but has not been managing the kidney condition for a period of time, would be precluded from making a referral for KDE services. Commenters stated that beneficiaries may be diagnosed late in the progression of their CKD and may not have been managed by a physician up to that point. Commenters recommended that we clarify the language in this provision so that physicians or other healthcare professionals that diagnose the beneficiary's kidney condition be able to refer the beneficiary for KDE services.

Response: Beneficiary access to these new services is important and we recognize the commenters' concerns about whether a beneficiary's kidney disease is being managed by a physician. Section 1861(ggg)(1)(B) of the Act expressly requires that KDE services are ''(B) furnished, upon the referral of the physician managing the individual's kidney condition, by a qualified person[…]'' We interpret the statute to mean that referrals are made by physicians and KDE services are furnished by qualified persons. Appropriate referral of a patient is left to the discretion of the physician as described above. If a physician diagnoses and discusses KDE services, we consider this to be sufficient to be considered the physician managing the beneficiary's kidney condition. Therefore, the physician, within his or her discretion, can make a referral for KDE services.

Comment: One commenter requested that the physician managing the beneficiary's kidney condition, as part of the KDE program, should initiate a referral for Medical Nutrition Therapy (MNT). Commenters also recommended that referrals for MNT be added to the KDE standards for content.

Response: We recognize that MNT can be an important benefit available to beneficiaries with chronic kidney disease. The MNT benefit (42 CFR 410 Subpart G) has distinct eligibility criteria, though it does overlap somewhat with the eligibility criteria for KDE services. A qualified person that provides KDE services and a physician managing a beneficiary's kidney condition may want to consider making patients aware that MNT is a Medicare covered benefit that provides beneficiaries with chronic kidney disease information about proper nutrition. We encourage physicians, healthcare professionals, and beneficiaries to discuss whether a referral for MNT services would be appropriate. Referral of a patient for MNT services is left to the discretion of the physician. Therefore, we do not believe it would be appropriate to

[1] Levey, A.S., Greene, T., Kusek, J, and Beck, G.A. J Am Soc Nephrol. 2000. 11: p. 155A.; Levey, A.S., Bosch, J.P., Lewis, J.B., Greene, T., Rogers, N., and Roth, D. Ann Intern Med. 1999 Mar 16; 130(6):461–70.

include a requirement for referral to MNT services as part of the referral process or the standards for content for KDE services.

Therefore, in this final rule, we are retaining our proposed provisions for covered beneficiaries.

(3) Standards for Qualified Persons and Exclusions (§ 410.48(c))

We proposed requiring that a qualified person be able to properly receive Medicare payment under 42 CFR part 424 (Conditions for Medicare Payment). Consistent with section 1861(ggg)(2)(B) of the Act, we proposed to specifically exclude a hospital, CAH, SNF, CORF, HHA, or hospice that is physically located outside of a rural area under § 412.64(b)(ii)(C), except for a hospital or CAH that is treated as being located in a rural area under § 412.103. In addition, consistent with section 1861(ggg)(2)(B) of the Act, a renal dialysis facility is not a qualified person.

While we did not propose specific education, experience, training, and/or certification requirements in the proposed rule, we solicited public comments on the appropriate level of education, experience, training, and/or certification appropriate for a qualified person to effectively provide KDE services. Factors to consider included specific education and expertise regarding the topic and the ability to explain these areas for the purpose of patient education.

Comment: Many commenters recommended that qualified persons either be board certified in nephrology or have at least 2 years experience working primarily with kidney disease patients. Commenters believed that the suggested qualifications supported our objective that the qualified person be able to explain the subjects enumerated in the proposed rule.

Response: The recommended qualifications were popular among commenters, but to our knowledge, the recommendations are not universally agreed upon standards for educators in existing education programs. Therefore, we are not adding specific education/experience qualifications for qualified persons to this final rule with comment period.

In this final rule with comment period, we are retaining the proposed standards for the ''Qualified Persons and Exclusions'' provisions.

(4) Standards for Content of Kidney Disease Patient Education Services (§ 410.48(d))

We believe that patient education needs vary by severity of the disease, the age of the patient, the patient's comorbid conditions and disabilities, the patient's primary language and culture, and desire to learn more about the disease and treatment options. Education services are more effective if the services are tailored to meet an individual beneficiary's needs. We proposed that KDE services include the content as specified in proposed new § 410.48(d).

Commenters were overwhelmingly supportive of the proposed standards for content and provided suggestions for improvement.

Comment: Some commenters requested that we provide more detailed regulatory guidance regarding the minimum core curriculum to maintain consistency and a balanced/comprehensive nature of the education sessions. Specifically, the commenters requested:

- Nature and treatment for co-morbidities that accompany CKD such as anemia, mineral and bone disorders, diabetes, and high blood pressure;
- Separate vascular access into its own topic heading and specify the benefits and risks of each option, the need to preserve vasculature for creation of fistulas, and care of vascular access to avoid infection and stenosis;
- Transplantation including preparation for transplantation, pre-emptive transplantation and differences between living donor and deceased donor transplantation, immunosuppression, allocation policies, and lifestyle post-transplant;
- Smoking cessation;
- Use of non-steroidal anti-inflammatory agents;
- Impact of blood transfusions on transplant candidacy;
- Nutrition, risk of malnutrition, impact of dietary interventions on the progression to kidney failure, and pre-dialysis and dialysis patient dietary prescriptions;
- Conservative management without renal replacement therapy and palliative care as a therapeutic option; and
- Advanced directives education.

Response: We appreciate the suggestions provided. The intent of the standards for content is that qualified persons provide a comprehensive set of information, but allow qualified persons flexibility in specific session design to meet the needs of the individual beneficiary(s) involved. Anemia, mineral and bone disorders, diabetes, and high blood pressure are addressed under § 410.48(d)(1), management of comorbidities including for the purpose of delaying the need for dialysis. Vascular access options, impact of blood transfusions on transplant candidacy, preparation for transplantation, pre-emptive transplantation, differences between living donor and deceased donor transplantation, immunosuppression, allocation policies, and lifestyle post-transplant are addressed under § 410.48(d)(3), therapeutic options, where we specify that qualified persons discuss the advantages and disadvantages of each therapeutic option. Regarding smoking cessation, conservative management without renal replacement therapy, palliative care as a therapeutic option, and advanced directives are addressed in § 410.48(d)(4), opportunities for beneficiaries to actively participate in the choice of therapy and be tailored to meet the needs of the individual beneficiary involved. Nutrition, risk of malnutrition, impact of dietary interventions on the progression to kidney failure, and pre-dialysis and dialysis patient dietary prescriptions are addressed in § 410.48(d)(2), prevention of uremic complications, under diet and fluid restrictions; and medication review, including how each medication works, possible side effects and minimization of side effects, the importance of compliance, and informed decision-making if the patient decides not to take a specific drug. The topics we list in § 410.48(d) do not constitute an all inclusive list. Specifically, we are stating with this final rule that the education provided to beneficiaries includes, but is not limited to the content standards topics listed in new § 410.48(d). We leave it to the discretion of the qualified person to tailor the services to individual needs.

Comment: One commenter requested that CMS include language stating that KDE services include, but are not limited to, the content as specified in § 410.48(d) and permit qualified providers to include additional reasonable and necessary content at their discretion.

Response: Under the standards for content, each content heading specifies that education sessions include, but are not limited to, the topics listed. We note that in the proposed rule § 410.48(d)(3), Therapeutic options, the ''not limited to'' language was inadvertently omitted. In this final rule, we are correcting this omission and clarifying that qualified persons discuss, but are not limited to, the topics listed under this content heading.

Comment: Some commenters requested standardized content. One commenter recommended the KDOQI guidelines as a source for standardization criteria.

Response: We understand and appreciate the suggestion that the KDE

services content should be standardized. The intent of the standards for content is consistent with the statutory provisions at section 1861(ggg)(1)(C)(iii) of the Act, which state that KDE services ''be tailored to meet the needs of the individual involved.'' The intent of the standards for content was to strike a balance between ensuring that beneficiaries are provided comprehensive information, but also that the services are tailored to individual needs. We outlined the major topics in the content standards that need to be addressed during KDE sessions, but also believe it is important to allow flexibility for qualified persons to tailor the education sessions to meet the needs of the beneficiaries involved, per the statutory requirements.

Comment: Commenters stated that the terminology ''vascular access'' does not encompass peritoneal dialysis access and recommended that we change the terminology to ''dialysis access for both hemodialysis and peritoneal dialysis.''

Response: We agree with the comments provided regarding vascular access and we are changing ''all vascular access options'' to ''all dialysis access options for hemodialysis and peritoneal dialysis.''

(5) Session Specifications (§ 410.48(e))

(a) Limitations on the number of sessions: Consistent with section 1861(ggg)(4) of the Act, we limit the number of KDE sessions to six (6). We did not receive any comments on the session limitations. Therefore, we are adopting the limits, as proposed, in this final rule.

(b) Session Length: In the proposed rule we defined the session length as 60 minutes.

Comment: One commenter concurred that 6 hours was sufficient to provide comprehensive KDE services, but recommended that we recognize a partial/fraction of a session. For example, one session could be billed in four 15-minute increments, to allow for variation in session length based on beneficiary needs.

Response: Consistent with section 1861(ggg)(4) of the Act, we limit the number of KDE sessions to six (6). As we discussed in the proposed rule, stakeholders provided a variety of recommendations regarding appropriate session length. In the absence of supporting evidence for session length, we are defining the session length in this final rule as one (1) hour, which coincides with the session length of some programs in existence and is the approximate average of stakeholder suggested session lengths.

(c) Individual and Group Session Format: Consistent with section 1861(ggg)(C)(iii) of the Act, we specify that the qualified person tailor the design of the education services to meet the needs of the beneficiary based on whether the beneficiary needs more individualized education, would benefit more from a group environment, or a combination; and consider any communication accessibility needs based on disability, language and health literacy.

Generally speaking, medical services are provided to beneficiaries on an individual basis. Beneficiaries can also benefit from the interaction in a group setting. We believe that the beneficiary, in consultation with the referring physician, will be able to best determine the education services modality that most effectively meets his or her needs.

Comment: One commenter recommended that we needed to build in flexibility of group versus the individual setting since some patients are more comfortable in the group setting. Other patients may be traumatized by the prospect of dialysis and need more individualized attention. One commenter suggested that the initial KDE education should be standardized and then later sessions be customized to meet patient specific needs. Another commenter requested that we mandate that at least 2 or more of each of the beneficiary's 6 KDE sessions be provided in a one-on-one format.

Response: We recognize that each individual, in consultation with the physician managing their kidney condition, are best able to determine the education services modality that most effectively meets his or her needs, whether that be group sessions, individual sessions, or a combination. The provisions of this rule allow for such flexibility.

Comment: One commenter requested an equal level of intensity for all sessions.

Response: In the final rule, we state that each KDE session is one (1) hour long, which addresses the commenter's concerns regarding session intensity.

Comment: One commenter requested that qualified persons should provide material that is specific to the patient, taking into account the patient's primary language, reading level, and comprehension level.

Response: We recognize the importance of providing beneficiaries with information in a format that is easy to comprehend. The provisions of the final rule allow that the KDE services be tailored to meet the needs of the individual beneficiary involved. We also address the commenter's concerns as part of the outcomes assessment process. This final rule with comment period states that the outcomes assessments will serve to assess KDE program effectiveness in meeting the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy.

Comment: One commenter recommended that we define a group session as consisting of between 2 and 20 participants.

Response: In § 410.48(e)(2) of this final rule, we specify that a session is one (1) hour long and may be provided individually or in group settings of 2 to 20 individuals who need not all be Medicare beneficiaries. We believe that this provision addresses the commenter's concerns about group size.

(6) Outcomes Assessment

The intent of the education services is for the beneficiary to take the information he or she has learned during the educational sessions in order to facilitate active participation by the beneficiary in the healthcare decision-making process with the physician managing his or her kidney condition. We believe that it is important that beneficiaries be assessed at the conclusion of the education sessions and that program assessments be used by the educators and CMS to assess the effectiveness of the education services, to help improve the programs for future participants, and better facilitate patient understanding of the material.

Based on stakeholder feedback and our general rulemaking authority, we proposed that qualified persons develop outcomes assessments and that each beneficiary be assessed during one of the education sessions. Section 410.48(d)(5) specifies that the outcomes assessment measures beneficiary knowledge about CKD and its treatment for the purpose of, and as a contributor to, the beneficiary's ability to make informed decisions regarding their healthcare and treatment options.

After completing the KDE services, the beneficiary should be able to take the information learned and use it to make informed choices about their healthcare during future consultations with the physician managing the beneficiary's kidney condition. It is important that the assessments be tailored to the beneficiary's reading level and language if the assessment is not administered by the qualified person that provided the education services, and be made available to CMS in a summarized format upon request. In the proposed rule, we specifically

solicited public comments regarding the development and administration of the outcomes assessments.

Comment: Commenters recommended both pre- and post-assessments and comparison studies of those beneficiaries that participated in KDE versus individuals that did not obtain the KDE services. Commenters recommended that the assessments cover topics specific to the content discussed during the KDE sessions, suggested that we work with stakeholders to develop standardized assessment tools, and provide a flexible implementation schedule that accounts for the time necessary for providers to adopt the new assessment instruments. Some commenters stressed the importance of long term post-assessment and follow-up by the physician managing the beneficiary's kidney condition, along with adoption of incentives to encourage providers to undertake such assessments. One commenter recommended that we re-evaluate the assessments over time to ensure that they address the most relevant topics and are administered effectively. One commenter requested standardized curriculum, evaluation, and monitoring tools.

Response: We are encouraged by the support from commenters about the development of outcomes assessments. After reviewing the feedback received during the stakeholders meetings and from commenters, there does not appear to be a standardized or agreed upon outcomes assessment mechanism. While we are not making any changes in this final rule from the proposed outcomes assessment provisions, we are considering working with organizations that are developing outcomes assessments as they work to develop a standardized assessment tool.

Comment: One commenter suggested that we develop an outcomes measure for ''physician referral for medical nutrition therapy'' as one of the monitoring tools.

Response: We appreciate the importance of proper nutritional counseling services. Since the outcomes assessment is part of the KDE services, it will not be paid separately and there is no need for a separate reporting tracking code.

Comment: One commenter requested clarification about whether pre- and/or post-assessments are included as part of the 6 sessions or in addition to the 6 sessions and whether there would be a separate reporting code and payment for the assessments.

Response: Outcomes assessments must be administered during a KDE session, meaning that the assessments are included as part of the sessions. Requests for separate reporting codes and payment for assessments would require a benefit category determination to determine if separate payment would fall within a Medicare benefit category.

Additional Issues

Comment: One commenter requested that we amend the ''Welcome to Medicare'' physical exam regulations to incorporate KDE as part of the preventive services checklist. Another commenter encouraged us to coordinate with Medicaid to examine whether stage IV education should be part of Medicaid case management services.

Response: We appreciate the attention being drawn to the importance of coordination with other benefits and programs such as the ''Welcome to Medicare'' physical exam and the Medicaid program. The commenter's requests do not fall within the scope of this rule. However, we plan to convey the commenter's suggestions to the appropriate components.

Comment: One commenter recommended that we promote the KDE program and the MNT benefit to beneficiaries and physicians.

Response: Medicare will release appropriate manual and transmittal instructions and information from our educational components for the medical community, including an MLN Matters article (Medicare Learning Network). The medical community can join this effort in educating physicians and beneficiaries by distributing their own communications, bulletins, or other publications. In addition, we have included information on the KDE benefit in the 2010 version of the Medicare and You Handbook. While we understand the importance of the MNT benefit, the commenter's request for promotion of the MNT benefit does not fall within the scope of this rule.

As a result of the comments received, we are making the following changes in this final rule with comment period:

- In the Standards for Content section, we are changing ''all vascular access options'' to ''all dialysis access options for hemodialysis and peritoneal dialysis.''
- In the standards for content section, we are clarifying that qualified persons discuss, but not be limited to, the topics listed under the 'therapeutic options' content standard heading.
- In the Limitations for Coverage of Kidney Disease Education Services section, we are changing the description of session length from ''60 minutes'' to ''one (1) hour.''

d. Payment for KDE Services

Section 152(b) of the MIPPA creates a new benefit category for KDE services. The MIPPA amends section 1848(j)(3) of the Act, which allows for payment of KDE services under the PFS. As we stated in the CY 2010 PFS proposed rule (74 FR 33619), KDE services are covered when they are furnished by a qualified person as defined in § 410.48(a) that meets the requirements of § 410.48(c) which means a physician, PA, NP, CNS, or a provider of services located in a rural area including a CAH, SNF, HHA, CORF, and hospice. We note that there is a possibility that a beneficiary may receive services from more than one ''qualified person''; however, payment should be made to only one qualified person on the same day for the same beneficiary.

In the proposed rule, we noted that the ''incident to'' requirements for physician services at section 1861(s)(2)(A) of the Act do not apply to KDE services. The MIPPA requirements are explicit, that the education services must be provided by a qualified person. We noted that rural health clinics (RHCs) do not meet the statutory definition of a provider of services (as defined in 1861(u) of the Act) and cannot be separately paid for furnishing KDE services.

In the proposed rule, we noted that the ''incident to'' provision does not apply to the implementation of a new service with a distinct benefit category under the PFS. We stated that the ''incident to'' requirements would not apply to KDE services.

Comment: Some commenters stated that CMS has the discretion and flexibility to allow KDE services to be provided ''incident to'' unless the statute explicitly precludes it. They also stated that section 152(b) of the MIPPA requires that KDE be furnished by a ''qualified person'', which includes physicians and specified nonphysician practitioners (NPPs) and that the statute does not prohibit KDE from being performed ''incident to'' the services of a ''qualified person''. Commenters also stated that CMS should allow a qualified person, as defined in section 152(b) of the MIPPA, to bill an E/M code on the same day as a KDE service.

Response: We do not agree that CMS has discretion to allow KDE services to be furnished incident to because the MIPPA specifically provides a benefit policy for KDE and that policy is different from incident to policy. In the December 31, 2002 final rule (67 FR 79994), we stated that ''Congress specifically provided for the many separate benefit categories of medical

and health services in the Act. We believe that the Congress intended for incident to services to be a catch-all category to allow payment for certain services and supplies commonly furnished in a physician's office and not having their own separate benefit category. The billing of services with their own separate and independent coverage benefit categories as incident to may circumvent the coverage and payment rules applicable to those other categories. Therefore, only services that do not have their own benefit category are appropriately billed as incident to a physician service.'' KDE has a benefit category with its own policies. For example, section 152(b) of the MIPPA requirements is explicit, that the education services must be provided by a qualified person, which is defined as a physician, NP, CNS or PA. A qualified person may include a provider of services located in a rural area. Therefore, the ''incident to'' requirements will not apply to KDE services. A qualified person can bill an E/M service on the same day they bill for a KDE service if the services being provided are not the same services which are included in KDE under our regulations at § 410.48.

Comment: A commenter stated that CMS has allowed separately and independently listed services to be provided under the ''incident to'' benefit. They also stated that CMS clarified in the CY 2002 PFS final rule that many services, even those that are separately and independently listed, can be furnished as ''incident to'' and need not meet the requirements of an ''incident to'' service.

Response: The commenter may be referring to policies prior to 2001. We have previously stated, ''In the November 2001 final rule (66 FR 5238), we revised regulations on services and supplies furnished incident to a physician's professional services. In the revised regulations at § 410.26(a)(7) we defined such services and supplies that may be provided as incident to as '* * * any services and supplies * * * that are included in section 1861(s)(2)(A) of the Act and are not specifically listed in the Act as a separate benefit included in the Medicare program.' '' (67 FR 79993) The commenter refers to one response to a comment in that rule that caused confusion. We repeated that comment at 67 FR 79994, column 1, and we clarified the intent of the response in column 2 of the same page. (See the previous response for the quotation that clarifies the intention of that response.) KDE has a benefit category with its own policies and, those policies are not the same as policies for services incident to physician services.

It is our policy that only services without a benefit category may be provided ''incident to'' the services of physicians or NPPs.

Comment: One commenter stated that while the patient's physician may know him or her, other members of the patient's multidisciplinary team may know them as well. The commenter also stated that the patient might receive better care if KDE services were provided by a team of persons such as nurses, dieticians, social workers and physicians, which could be done if we allow KDE to be provided incident to.

Response: The section 152(b) of the MIPPA requirements are explicit, in that the education services must be delivered by a qualified person, which is defined as a physician, NP, CNS, or PA, and also includes a provider of services located in a rural area.

Comment: A commenter stated that CMS has established subregulatory policy by which services furnished under the Medical Nutrition Therapy (MNT) and Diabetes Self Management Training (DSMT) benefits may not be provided ''incident to''. However, the commenter stated that there is no statutory or regulatory provision preventing those services from being performed ''incident to'' and that the services furnished under those benefits are not performed by physicians or NPPs. The commenter stated that the distinction is that the MNT and the DSMT benefits are furnished by practitioners who were previously not able to bill the Medicare program and who do not have an ''incident to'' benefit for their service. In contrast, the KDE benefit will be provided by practitioners who bill the Medicare program independently and who have an ''incident to'' benefit attached to their services.

Response: For separately and independently listed services, a physician and a NPP can bill using the ''incident to'' benefit. However, KDE is not defined as a separately and independently listed service, but as a separate and distinct benefit category and so the ''incident to'' benefit does not apply.

In summary we are finalizing our determination that the ''incident to'' benefit does not apply to KDE.

Section 1861(ggg)(4) of the Act limits the number of KDE services that a beneficiary may receive to up to six sessions in the NPRM. We proposed to create two HCPCS codes GXX26 now assigned as G0420 (individual) and GXX27 now assigned as G0421 (group), to describe and to bill for KDE services. The two G-codes consist of 1-hour face-to-face KDE sessions for an individual or group. We proposed to pay both G0420 and G0421 at the nonfacility rate. We also proposed that G0420 educational services related to the care of chronic kidney disease; individual per session will be crossed-walked to CPT code 97802; and that G0421, educational services related to the care of chronic kidney disease; group, per session will be crosswalked to CPT code 97804. We stated that the rationale for the proposed pricing of the G-codes is based on the similarity of this service to MNT in the individual (97802) and group (97804) setting.

In the CY 2010 OPPS/ASC proposed rule (74 FR 35358), we discussed our proposed payment for KDE to qualified persons located in rural areas who are hospitals, CAHs, SNFs, CORFs, HHAs, or hospices (74 FR 35358).

The following is a summary of the comments we received regarding our proposals related to the MPFS payment for kidney disease education under section 152(b) of the MIPPA.

Comment: One commenter suggested that CMS add the phrase ''furnished by a rural provider'' or similar language to the proposed Level II HCPCS G-code descriptors for KDE, to clarify that these services are intended for patients who solely meet the qualifications for coverage under the KDE benefit.

Response: We do not agree that the HCPCS G-code descriptors for KDE services should contain language that would limit their use to KDE services furnished by rural providers of services. The purpose of a HCPCS code is to describe a service furnished to a beneficiary. Generally code descriptors do not describe the provider who is furnishing these services. Adding a phrase to the G-code descriptors indicating that these services are furnished by a rural provider would exclude other qualified persons delineated in the Act from being able to bill and be paid for the KDE services they furnish. These qualified persons include a physician, PA, NP, or clinical nurse specialist, in addition to providers of services located in a rural area. Moreover, adding the language the commenter requests would not ensure that the service would be provided to patients who meet the criteria for coverage.

Comment: We received several comments stating that CMS accurately matched individual KDE to individual MNT and group KDE to group MNT. However, commenters stated that CMS did not take into account the relative time of the KDE and MNT sessions. The new KDE codes were cross-walked to

the MNT codes which are paid only for 15-minute individual sessions and 30-minute group sessions. We also received a comment concerning the inputs for supplies and equipment. In addition, commenters stating the proposed payment rates were too low to enable rural providers of services to furnish KDE.

Response: As a result of the comments we received and our own further analysis, we have adjusted the payment rates for G0420 and G0421 to reflect the 1-hour time limit for a session. We have multiplied the work RVUs for G0420 by four and the work RVUs for G0421 by two to account for the fact that we are crosswalking a 15 minute code to a 60 minute code (CPT code 97802 to G0420) and a 30 minute code to a 60 minute code (CPT code 97804 to G0421). We also adjusted the inputs for supplies. However, we did not do a straight multiplication of the actual inputs because we do not believe the required equipment and supplies would increase in direct proportion to the time for the codes. We did not increase the inputs for the body analysis machine and the printer and scale for use during the session. However, we did increase the inputs for equipment and supplies for the use of the table, computer, paper and other printed materials because regardless of how long the session is, it takes only 5 minutes to use the body/mass index item, 2 minutes to weigh the individual, and 2 minutes to use the printer (this time equals the number of pieces of paper).

Comment: A commenter stated that a significant portion of kidney education is about nutrition and diet and that the MNT benefit includes provisions of MNT to patients with kidney disease. Therefore, some kidney education is already being provided to Stage IV kidney patients through the MNT benefit and it would be inappropriate to pay four times more for nutrition education when it is provided under the MNT benefit than when the exact same education is provided under the kidney education benefit. The commenter also stated that MNT is provided by dieticians and KDE is provided by physicians and midlevel practitioners and the new G-codes should be cross-walked to the ''all physicians'' PE and not to the registered dieticians PE.

Response: As stated, we did adjust the inputs for supplies and equipment to eliminate any duplication. We also cross-walked the ''all physicians'' PE to HCPCS codes G0420 and G0421 at the mid-level office visit.

In summary, we are finalizing the proposed HCPCS codes G0420, *Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour,* and G0421, *Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour,* for KDE with the adjustments noted above. Refer to the Addendum B for the specific RVUs for G0420 and G0421.

12. Section 153: Renal Dialysis Provisions

Section 153 of the MIPPA requires changes to ESRD facilities for ESRD services effective January 1, 2010. The following is a summary of these changes.

Section 153(a)(1) of the MIPPA increases the current ESRD composite rate by 1.0 percent for services furnished on or after January 1, 2010. This also requires us to update the adjusted drug add-on. Since we compute the drug add-on adjustment as a percentage of the composite rate, the drug add-on percentage is decreased to account for the higher CY 2010 composite payment rate and results in a 15.0 percent drug add-on adjustment for CY 2010. As a result, the drug add-on amount of $20.33 per treatment remains the same for CY 2010, which results in a 15.0 percent increase to the base composite payment rate of $135.15 (see section II.I of this final rule with comment).

The composite rate paid to hospital-based facilities will be the same as the composite rate paid to independent renal dialysis facilities for services furnished on or after January 1, 2010, as required by section 153(a)(2) of the MIPPA. In addition, section 153(a)(2) of the MIPPA requires that in applying the geographic index to hospital-based facilities, the labor share shall be based on the labor share otherwise applied for renal dialysis facilities.

These MIPPA provisions are self-implementing and require no substantive exercise of discretion on the part of the Secretary. A detailed discussion of the MIPPA provisions can be found in section III. of the CY 2009 PFS final rule with comment period (73 FR 69881).

The following is summary of the comments we received regarding section 153 of the MIPPA.

Comment: One commenter supports the composite payment rates for both independent and hospital-based facilities be site neutral, and urges CMS to ensure that pediatric facilities are not adversely impacted by this adjustment.

Response: Section 153(a)(2) of the MIPPA requires the composite payment rate for both independent and hospital-based facilities to be site neutral and does not negatively impact pediatric facilities because, in addition to the composite payment rate, all pediatric facilities including hospital-based facilities are paid the basic case-mix adjustment of 1.62 for pediatric patients.

13. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen

a. Background

(1) Process for Revising the List of Statutorily Named Compendia

Generally, compendia are ''pharmacopeia providing information on drugs, their effectiveness, safety, toxicity, and dosing and are frequently used to determine whether a medication has a role in the treatment of a particular disease; these roles include both therapeutic uses approved by the U.S. Food and Drug Administration (FDA) and off-label indications'' (Agency of Healthcare Research and Quality (AHRQ), *Potential Conflict of Interest in the Production of Drug Compendia* White Paper).[2] Compendia are published by various institutions and by traditional reference book publishing houses.

Compendia publishers, including internal editorial staff and external experts, review requests received for the inclusion of recommendations regarding off-label uses of drugs or biologicals in anticancer regimens. These requests may be internally generated by the publisher or may be received as requests from external parties. The publisher reviews evidence related to the request and reaches a disposition of the request.

Section 1861(t)(2)(B)(ii)(I) of the Act lists the following compendia as authoritative sources for use in the determination of a ''medically-accepted indication'' of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen: American Medical Association Drug Evaluations (AMA–DE); United States Pharmacopoeia-Drug Information (USP–DI) or its successor publication; American Hospital Formulary Service-Drug Information (AHFS–DI); and other authoritative compendia as identified by the Secretary. Due to changes in the pharmaceutical reference industry, AHFS–DI was the only statutorily

[2] Agency for Healthcare Research and Quality. White Paper: Potential Conflict of Interest in the Production of Drug Compendia. (2009, April 27). Available online at *http://www.cms.hhs.gov/mcd/viewtechassess.asp?from2=viewtechassess.asp&where=index&tid=64&.*

named compendium in current publication in CY 2008.

Section 1861(t)(2)(B) of the Act provides the Secretary the authority to revise the list of compendia in section 1861(t)(2)(B)(ii)(I) for determining medically-accepted indications for off-label use of drugs and biologicals in an anti-cancer chemotherapeutic regimen. Consequently, in § 414.930, we established an annual process to revise the list and a definition of ''compendium'' in the CY 2008 PFS final rule with comment period (72 FR 66222, 66303 through 66306, and 66404).

Currently, four compendia are recognized for purposes of section 1861(t)(2) of the Act: National Comprehensive Cancer Network Compendium, Gold Standard Clinical Pharmacology, Thompson Micromedex DrugDex, and AHFS–DI.

In addition to these compendia, the statute provides an alternative method for identifying medically-accepted off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen. Section 1861(t)(2)(B)(ii)(II) of the Act provides that local contractors may use ''supportive clinical evidence in peerreviewed medical literature'' to make such determinations. Thus these medically-accepted uses could be identified even if there were no compendia recognized for this purpose. We discussed this in our response to comments in the CY 2008 PFS final rule with comment period (72 FR 66305).

(2) Statutory Amendment

Section 182(b) of the MIPPA amended section 1861(t)(2)(B) of the Act (42 U.S.C. 1395x(t)(2)(B)) by adding the sentence, ''On and after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.''

As discussed in the proposed rule, we proposed revisions to the compendia standards to implement the MIPPA amendments. We note that the publishers of the four compendia that are currently recognized for purposes of section 1861(t)(2) of the Act have already adopted conflict of interest disclosure policies that are similar to our proposal. Though there are individual differences among the publishers, we note that these policies commonly include publication on the compendia publisher's Web site of the name of the individuals that participate in the compendia recommendation and the entity with which there is a significant relationship, the nature of the relationship (for example, salary, ownership, grant support), and the value of the relationship.

Additional information with respect to the conflict of interest policies of those compendia can be found on their Web sites.

In addition, there is a growing body of literature, including that from the Institute of Medicine (IOM),[3] that discusses the conflict of interest between research funding and research results. We believe that section 182(b) of the MIPPA is designed, in part, to address this issue in the compendia review process. For a detailed discussion of our proposals concerning conflict of interest, see the CY 2010 PFS proposed rule (74 FR 33620 through 33623).

b. Provisions of the Proposed Regulation

As discussed in the proposed rule, we believe that the implementation of this statutory provision that compendia have a ''publicly transparent process for evaluating therapies and for identifying potential conflicts of interests'' is best accomplished by amending the current definition of a compendium at § 414.930(a) to include the MIPPA requirements and by defining the key components of publicly transparent processes for evaluating therapies and for identifying potential conflicts of interests.

In order to implement the MIPPA requirements concerning a publicly transparent process for evaluating therapies, we proposed that a compendium could meet this standard by publishing materials used in its evaluation process on its Web site. This mode of publication provides broad contemporaneous public access to relevant materials. We believe that public access to such materials will increase transparency of the process used by compendia publishers for evaluating therapies and facilitate independent review of recommendations by interested parties. In addition, as discussed in the CY 2008 PFS final rule with comment period (72 FR 66305 through 66306), such disclosure may assist beneficiaries and their physicians in choosing among treatment options.

In the CY 2010 PFS proposed rule (74 FR 33620 through 33623), we proposed the following amendments to § 414.930(a):

- To revise the definition of ''compendium'' by adding an additional requirement that a compendium have a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.
- To add a definition of a ''publicly transparent process'' for evaluating therapies whereby a compendium publisher would publish on its Web site the complete application for inclusion of a therapy including criteria used to evaluate the request; disclosure of the evidence considered; the names of the individuals who have substantively participated in the development of the compendia recommendations; and transcripts of meetings and records of votes for disposition of the request. We requested comments on the requirement for publication of the transcript and the suitability of other alternatives such as minutes or other documents.
- To add a definition of a ''publicly transparent process for identifying potential conflicts of interests'' whereby a compendium publisher would disclose by publication on its Web site information regarding potential conflicts of interests associated with individuals who are responsible for the compendium's recommendations, as well as their immediate family members. We requested comments on the suitability of this process or whether the compendia should prescribe their own process. The specific details of the proposed process were outlined in the proposed rule (74 FR 33621 through 33623). We received the following comments on our proposed revisions.

c. Public Comment and Response

Comment: Commenters generally agreed with the principle that conflicts of interest pose a risk to the integrity of compendia and should be minimized.

Response: We appreciate the general support for the principle.

Comment: Some commenters were concerned with the technological burden of maintaining disclosable information publicly on the compendia Web sites for a 5-year period.

Response: Public interest in the review and disposition of a request pertaining to a drug or biological may in some cases arise only after a drug or biological has been in widespread use for several years, during which its risks or adverse effects become apparent. In order to balance the burden on the compendia publishers with the public's interest in timely access to this information, we are revising our proposal to require that the publicly transparent process provide for disclosures to remain available on the compendium's Web site for not less than 3 years. However, for the reasons discussed in the proposed rule (see 74

[3] Institute of Medicine. Conflict of Interest in Medical Research, Education, and Practice. Available online at *http://www.nap.edu/catalog.php?record_id=12598.*

FR 33622 through 33623), the compendia should retain custody of the relevant information, enabling public access to the material upon request for not less than 5 years.

Comment: Commenters suggested that the burden of disclosing conflict of interest information regarding individuals who participate substantively in the review and disposition of multiple requests could be lessened if there were no requirement to separately disclose this information for each and every request.

Response: We recognize that some individuals may participate substantively in the review and disposition of more than one request. However, we also recognize that a single relationship may present a significant conflict of interest in some cases but not others. Therefore, we are requiring compendia in establishing a publicly transparent process for identification of potential conflicts of interest, to list the names of those individuals who substantively participated in the review or disposition of each request.

Comment: Some commenters were concerned that the immediate removal of a compendium that fails to meet the statutorily-mandated January 1, 2010 implementation date as specified by section 182(b) of the MIPPA would adversely impact a patient being treated with an off-label anti-cancer chemotherapeutic regimen based on a recommendation from that compendium. One commenter suggested grandfathering patients that began an off-label anti-cancer chemotherapeutic regimen based the recommendation of a compendium that is removed from the list of statutorily recognized compendia based on noncompliance with section 182(b) of the MIPPA.

Response: The statute provides an alternative method for identifying medically-accepted off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen. In accordance with section 1861(t)(2)(B)(ii)(II) of the Act, local contractors have additional authority to make determinations regarding medically-accepted indications. We discussed this in our response to comments in the CY 2008 PFS final rule with comment period (72 FR 66305).

Comment: A few commenters were concerned that the proposed publicly transparent process for evaluating therapies might be interpreted to apply only to externally generated requests received by compendia.

Response: We appreciate this comment and have clarified this provision, because in some instances, a compendium's determination is internally generated. Therefore, we have added text to clarify that the requirements pertain to an internally or externally generated request.

Comment: Some of the commenters were concerned that requiring transcripts would inhibit discussion amongst compendia recommendation decision makers and would be too burdensome to compendia publishers because of the number or length of meetings, which may include discussion of topics beyond the request. The commenters suggested requiring minutes and voting records rather than transcripts. One commenter suggested that we delay the implementation of this requirement for up to 1 year.

Response: We agree that publication of minutes and voting records would be sufficient because it would provide public transparency regarding the evaluation of the therapy at issue. We also believe that this requirement can be implemented much more readily than the proposed requirement for transcripts.

Comment: A few commenters were concerned about the requirement for compendia to publicly transcribe all meetings pertaining to compendium recommendations. Specifically, some compendia publishers convene telephone conferences rather than meetings or have processes that isolate advisors from each others' recommendations.

Response: We have replaced the transcript requirement as noted above. However, this comment remains relevant as we have been made aware that some compendia publishers do not conduct actual meetings of individuals substantively involved in reviewing and reaching dispositions of requests and thus could not provide minutes of meetings. We believe that minutes of telephone conferences, to the extent that such conferences are used in the evaluation of the request, could also be used to demonstrate the evaluation process used by the compendia.

Comment: One commenter questioned the use of § 411.354 to define direct and indirect financial conflicts of interests.

Response: In the proposed rule, we stated that the process for identifying potential conflicts of interest should include disclosure of direct and indirect ''similar to those relationships identified in 42 CFR part 411.'' Compendia maintain discretion to develop their own definitions for direct and indirect financial conflicts of interests, however, the definitions included in 42 CFR part 411 are provided as a resource for compendia to use in the development of these definitions.

Comment: One commenter suggested that we establish a specific dollar value that would trigger disclosure of financial conflicts of interests that exceed some minimum amount.

Response: We are not requiring compendia to disclose a specific dollar amount. We have left it to the discretion of the compendia publisher as to whether a specific dollar value would be publicly disclosed.

Comment: Many commenters expressed support for the disclosure of the conflicts of interests of individuals who are responsible for the compendium's recommendations, as well as their *immediate family members*. There was concern from some commenters that the definition of immediate family member in § 411.351 (which includes, in part, relationships with a spouse, children, and grandparents) was too extensive.

Response: We agree with this comment and are amending the provision concerning the process for public disclosure of immediate family members to be less extensive and more consistent with the current FDA *Guidance for the Public, FDA Advisory Committee Members, and FDA Staff on Procedures for Determining Conflict of Interest and Eligibility for Participation in FDA Advisory Committees* released in August of 2008.

We have also amended the publicly transparent process for identifying potential conflicts to include a provision that requires compendia to have a process for collecting and maintaining conflict of interest information and disclosure, if requested by the public in lieu of publishing this information on their Web sites. We believe this strikes a reasonable balance between the individual's personal privacy and the public interest in transparency.

Comment: Some requestors asked if the regulatory requirements would apply to past requests that were received or under review by compendia publishers before January 1, 2010 that may have led to treatment recommendations that are published after that date.

Response: These provisions would not apply retroactively. However, the MIPPA provisions are effective on or after January 1, 2010. Thus, compendia are responsible for complying with these provisions with respect to requests received after the date.

d. Provisions of the Final Regulation

This final regulation amends § 414.930(a) to revise the definition of

compendium to add a requirement that a compendium have a publicly transparent process for evaluating therapies and for identifying conflicts of interests. We also define a publicly transparent process for evaluating therapies and for identifying conflicts of interests. The revised definitions read as follows:

• *Publicly transparent process for evaluating therapies* means that the process provides that the following information from an internal or external request for inclusion of a therapy in a compendium are available to the public for a period of not less than 5 years, which includes availability on the compendium's Web site for a period of not less than 3 years, coincident with the compendium's publication of the related recommendation:

(i) The internal or external request for listing of a therapy recommendation including criteria used to evaluate the request.

(ii) A listing of all the evidentiary materials reviewed or considered by the compendium pursuant to the request.

(iii) A listing of all individuals who have substantively participated in the review or disposition of the request.

(iv) Minutes and voting records of meetings for the review and disposition of the request.

• *Publicly transparent process for identifying potential conflicts of interests* means that the process provides that the following information is identified and made timely available in response to a public request for a period of not less than 5 years, coincident with the compendium's publication of the related recommendation:

(i) Direct or indirect financial relationships that exist between individuals or the spouse or minor child of individuals who have substantively participated in the development or disposition of compendia recommendations and the manufacturer or seller of the drug or biological being reviewed by the compendium. This publicly transparent process may include disclosure of, for example, compensation arrangements such as salary, grant, contract, or collaboration agreements between individuals or the spouse or minor child of individuals who have substantively participated in the review and disposition of the request and the manufacturer or seller of the drug or biological being reviewed by the compendium.

(ii) Ownership or investment interests between individuals or the spouse or minor child of individuals who have substantively participated in the development or disposition of compendia recommendations and the manufacturer or seller of the drug or biological being reviewed by the compendium.

H. Part B Drug Payment

1. Average Sales Price (ASP) Issues

a. Immunosuppressive Drugs Period of Eligibility

Before enactment of section 9335(c) of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509) (OBRA '86), there was no specific Medicare benefit that provided for Medicare Part B coverage of prescription drugs used in immunosuppressive therapy. OBRA '86 added subparagraph (J) to section 1861(s)(2) of the Act to provide Medicare coverage for immunosuppressive drugs, furnished to an individual who receives an organ transplant for which Medicare payment is made, for a period not to exceed 1 year after the transplant procedure. Coverage of these drugs under Medicare Part B began January 1, 1987.

Section 13565 of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103–66) amended section 1861(s)(2)(J) of the Act to allow eligible beneficiaries to receive additional Part B coverage within 18 months after the discharge date for immunosuppressive drugs furnished in 1995; within 24 months for immunosuppressive drugs furnished in 1996; within 30 months for immunosuppressive drugs furnished in 1997; and within 36 months for immunosuppressive drugs furnished after 1997. Beginning January 1, 2000, section 227 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106–113) (BBRA) extended coverage to eligible beneficiaries whose coverage for drugs used in immunosuppressive therapy expires during the calendar year, an additional 8 months beyond the 36-month period.

Section 113 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) (BIPA 2000) revised section 1861(s)(2)(J) of the Act to eliminate the time limits for coverage of prescription drugs used in immunosuppressive therapy under the Medicare program. Effective with immunosuppressive drugs furnished on or after December 21, 2000, there is no longer any time limit for Medicare benefits. This policy applies to all Medicare entitled beneficiaries who meet all of the other program requirements for coverage under this benefit. Therefore, for example, entitled beneficiaries who had been receiving benefits for immunosuppressive drugs under section 1861(s)(2)(J) of the Act, but whose immunosuppressive drug benefit was terminated solely because of the time limit described above, resumed receiving that benefit for immunosuppressive drugs furnished on or after December 21, 2000.

According to section 226A(b)(2) of the Act, ''ESRD only'' beneficiaries continue to lose their general Medicare coverage and, by extension, Part B coverage for immunosuppressive drug therapy 36 months after discharge from a hospital following a covered transplant. Beneficiaries will have Part B coverage for immunosuppressive drug therapy for as long as they remain eligible for Medicare.

Our proposal to codify the immunosuppressive drug coverage does not cause a substantive programmatic change since the provisions in section 113 of the BIPA 2000 eliminating the time limit from section 1861(s)(2)(J) of the Act are self implementing for services on or after December 21, 2000. We included this topic in the proposed rule in order to make conforming changes to the regulatory text at § 410.30. We proposed to amend paragraph (b) to codify the changes to the immunosuppressive drug coverage time limit as required by section 113 of the BIPA 2000.

The following is a summary of the comments we received and our responses:

Comment: We received a few comments which supported our proposal. Commenters noted that this technical change will reduce the potential for confusion in the future about the scope of Medicare coverage of and payment for immunosuppressive drug therapy.

Response: We appreciate the supportive comments and agree that any steps which reduce confusion benefit Medicare and its stakeholders.

After reviewing the public comments, we are finalizing our proposed revisions to § 410.30.

b. WAMP/AMP Threshold

Section 1847A(d)(1) of the Act states that ''the Inspector General of HHS shall conduct studies, which may include surveys to determine the widely available market prices (WAMP) of drugs and biologicals to which this section applies, as the Inspector General, in consultation with the Secretary, determines to be appropriate.'' Section 1847A(d)(2) of the Act states that, ''Based upon such studies and other data for drugs and biologicals, the Inspector General shall compare the ASP under this section for drugs and biologicals with—

• The widely available market price (WAMP) for these drugs and biologicals (if any); and

• The average manufacturer price (AMP) (as determined under section 1927(k)(1) of the Act for such drugs and biologicals).''

Section 1847A(d)(3)(A) of the Act states that, ''The Secretary may disregard the ASP for a drug or biological that exceeds the WAMP or the AMP for such drug or biological by the applicable threshold percentage (as defined in subparagraph (B)).'' The applicable threshold is specified as 5 percent for CY 2005. For CY 2006 and subsequent years, section 1847A(d)(3)(B) of the Act establishes that the applicable threshold is ''the percentage applied under this subparagraph subject to such adjustment as the Secretary may specify for the WAMP or the AMP, or both.'' In CY 2006 through CY 2009, we specified an applicable threshold percentage of 5 percent for both the WAMP and AMP. We based this decision on the limited data available to support a change in the current threshold percentage.

For CY 2010, we proposed to specify an applicable threshold percentage of 5 percent for the WAMP and the AMP. At present, the OIG is continuing its comparisons of both the WAMP and the AMP. In April 2008, we implemented a change in the weighting methodology for calculating ASP. Information on how recent changes to the calculation of the ASP may affect the comparison of ASP to WAMP or AMP is limited at this time. In addition, due to the ongoing legal issues surrounding the availability of AMP, we believe it is prudent not to change the threshold at this time. Since we do not have sufficient data that suggest another level is more appropriate, we believe that continuing the 5 percent applicable threshold percentage for both the WAMP and AMP is appropriate for CY 2010.

As we noted in the CY 2009 PFS final rule with comment period (73 FR 69752), we understand that there are complicated operational issues associated with potential payment substitutions. We will continue to proceed cautiously in this area and provide stakeholders, including providers and manufacturers of drugs impacted by potential price substitutions with adequate notice of our intentions regarding such, including the opportunity to provide input with regard to the processes for substituting the WAMP or the AMP for the ASP.

The following is a summary of the comments we received and our responses:

Comment: Most commenters supported maintaining the threshold at 5 percent. Other comments suggested that we exercise caution in the determination of price substitutions and that we develop a formal process and criteria to determine when substitutions are necessary. Comments also recommended that we provide adequate notice prior to making a price substitution. One commenter objected to the continuation of the 5 percent threshold but did not provide an alternative solution.

Response: We appreciate the comments supporting the continuation of the 5 percent threshold. As we noted in the CY 2009 PFS final rule with comment period (73 FR 69753), we understand there are complex operational issues associated with potential payment substitutions. As we continue to proceed in this area, we will provide stakeholders, including providers and manufacturers of drugs impacted by potential price substitutions an opportunity to provide input with regard to the processes for substituting the WAMP or the AMP for the ASP. As part of our approach we intend to develop a better understanding of the issues that may be related to certain drugs for which the WAMP and AMP may be lower than the ASP over time.

After reviewing the public comments, we are finalizing our proposal to continue the 5 percent WAMP/AMP threshold for CY 2010.

2. Competitive Acquisition Program (CAP) Issues

Section 303(d) of the MMA requires the implementation of a competitive acquisition program (CAP) for certain Medicare Part B drugs not paid on a cost or PPS basis. The provisions for acquiring and billing drugs under the CAP were described in the Competitive Acquisition of Outpatient Drugs and Biologicals Under Part B proposed rule (March 4, 2005, 70 FR 10746) and the interim final rule (July 6, 2005, 70 FR 39022), and certain provisions were finalized in the CY 2006 PFS final rule with comment period (70 FR 70236). The CY 2007 PFS final rule with comment period (72 FR 66260) then finalized portions of the July 6, 2005 IFC that had not already been finalized.

The CAP is an alternative to the ASP (buy and bill) methodology of obtaining certain Part B drugs used incident to physicians' services. Physicians who choose to participate in the CAP obtain drugs from vendors selected through a competitive bidding process and approved by CMS. Under the CAP, participating physicians agree to obtain all of the drugs on the CAP drug list from an approved CAP vendor. The approved CAP vendor retains title to the drug until it is administered, bills Medicare for the drug, and bills the beneficiary for cost sharing amounts once the drug has been administered. The participating CAP physician bills Medicare only for administering the drug to the beneficiary. The initial implementation of the CAP operated with a single CAP drug category from July 1, 2006 to December 31, 2008.

After the CAP was implemented, section 108 of the MIEA–TRHCA made changes to the CAP payment methodology. Section 108(a)(2) of the MIEA–TRHCA requires the Secretary to establish (by program instruction or otherwise) a post payment review process (which may include the use of statistical sampling) to assure that payment is made for a drug or biological only if the drug or biological has been administered to a beneficiary. The Secretary is required to recoup, offset, or collect any overpayments. This statutory change took effect on April 1, 2007. Conforming changes were proposed in the CY 2008 PFS proposed rule (72 FR 38153) and finalized in the CY 2008 PFS final rule with comment period (72 FR 66260).

In the CY 2009 PFS proposed rule, we proposed several refinements to the CAP regarding the annual CAP payment amount update mechanism, the definition of a CAP physician, the restriction on physician transportation of CAP drugs, and the dispute resolution process (73 FR 38522). However, after the publication of the CY 2009 proposed rule, we announced the postponement of the CAP for 2009 due to contractual issues with the successful bidders. As a result, CAP physician election for participation in the CAP in 2009 was put on hold, and CAP drugs have not been available from an approved CAP vendor for dates of service after December 31, 2008. Physicians who participated in the CAP have transitioned back into the Average Sales Price (ASP) method of acquiring part B drugs for dates of service after December 31, 2008.

After the postponement was announced, we solicited public feedback on the CAP from participating physicians, potential vendors, and other interested parties. We solicited public comments on several issues, including, but not limited to the following: the categories of drugs provided under the CAP; the distribution of areas that are served by the CAP; and procedural changes that may increase the program's flexibility and appeal to potential vendors and participating physicians.

We also hosted a CAP Open Door Forum (ODF) on December 3, 2008, where participants had an opportunity to discuss the postponement and suggest changes to the program.

In the CY 2009 PFS final rule with comment period, we stated that we would review the public comments and consider implementing changes to the CAP before proceeding with another bid solicitation for approved CAP vendor contracts. Based on this information, we addressed items that were not finalized in the CY 2009 PFS final rule with comment period, and made additional proposals for the CAP. Our approach seeks to better define certain aspects of the program based on our experience. We also seek to continue to increase participation by minimizing the administrative burden for physicians and vendors who choose to participate. We appreciate the additional comments that we have received during the comment period.

a. Frequency of Drug Payment Amount Updates

As described in the July 6, 2005 IFC (70 FR 39070 through 39071) and § 414.906(c), payment amounts for drugs furnished under the CAP are set through a competitive bidding process, and as described in § 414.908(b), bids that exceed a composite bid threshold of 106 percent of the weighted ASP for the drugs in the CAP category are not accepted. The CAP payment amounts that are calculated from successful bids are updated from the time of the bidding period to the payment year. During the 2006 through 2008 CAP contract period, the initial update calculation used the change in the Producer Price Index (PPI) for prescription preparations to account for the time period between the bidding and the period in which the payment amounts were to be in effect, which was the middle of the first year of the three year CAP contract period (70 FR 39074). Finally, as specified in § 414.906(c), CAP payment amounts were updated again during the second and third year of the contract period based on the approved CAP vendor's reported reasonable net acquisition costs (RNAC). The annual updates are limited by payment amounts described in section 1847A of the Act and codified in § 414.906(c).

Section 1847B(c)(7) of the Act gives the Secretary the discretion to establish an appropriate schedule for the approved CAP vendor's disclosure of RNAC information to us, provided that disclosure is not required more frequently than quarterly. In the July 6, 2005 IFC (70 FR 39075 through 39076), we specified that each approved CAP vendor will disclose its RNAC for the drugs covered under the contract annually during the period of its contract and that we would calculate an annual payment adjustment based on this information. We specified an annual disclosure of RNAC because it imposes the minimal burden on approved CAP vendors. In 2005, some commenters suggested that more frequent updates would be desirable. Additional feedback about the CAP that was obtained after the program's postponement in 2008, as well as comments on previous rules, indicated that potential vendors would like the frequency of price adjustments to increase. In the past, various commenters have suggested a quarterly price adjustment in order to parallel the ASP process, to better match payment amounts with increases or decreases in drug costs, and to attract vendor interest. We believe that quarterly adjustments also would lower approved CAP vendors' financial risks because CAP payment amounts will be better able to keep up with unanticipated drug cost increases and would benefit the Medicare program by reacting to significant cost decreases more promptly.

Quarterly price updates also will eliminate the PPI-based increase that currently occurs between the time bids are submitted and the first day of CAP claims processing. The application of the PPI-based payment adjustment described in the July 6, 2005 IFC (70 FR 39074) has resulted in situations where the ASP+6 percent payment amount was exceeded during the first year of the 3-year approved CAP vendor contract. We do not believe that CAP payment amounts should exceed ASP+6 percent. In our discussion of bid ceilings in the July 6, 2005 IFC, we stated that the bid ceiling ''ensures that the CAP will be no more costly to the Medicare program than the alternative method of paying for drugs at 106 percent of ASP. This ceiling is thus consistent with the possibility of realizing savings to the Medicare program. It would also serve to maintain a level of parity between the two systems, preventing a situation in which significant payment differentials might skew incentives and choices (70 FR 39070).'' For this reason, and to remain consistent with current regulation text at § 414.906, we believe that all payment amounts calculated under the update process should be limited by the weighted payment amount established under section 1847A of the Act. We also believe that this approach will continue to provide for an ''appropriate price adjustment'' as required under section 1847B(c)(7) of the Act by improving responsiveness to unexpected price changes, and continuing a prudent limitation on the magnitude of payment amount adjustments.

Our approach for implementing quarterly updates is consistent with the ASP+6 percent limit on payment amounts and is based on composite bid price calculations, as described in the July 6, 2005 IFC (70 FR 39072 through 39073). Briefly stated, the ASP+6 percent limit would be applied by comparing the (weighted) composite update payment amount, calculated from participating approved CAP vendors' reasonable net acquisition cost data, to the most recent available weighted ASP prices for the same drugs. If the composite drug update payment amount exceeds the weighted ASP+6 percent payment limit, the composite payment amount for that group of drugs would be reduced to equal the ASP+6 percent limit by applying an equal percent reduction to each drug in the group. By way of example only, if a quarter's composite update payment was calculated as +2.3 percent, based on the median of all participating approved CAP vendors' data, but the calculated weighted ASP+6 percent limit for that group of drugs was +2.1 percent, the payment amounts for all HCPCS codes in the composite group would be increased by 2.1 percent in order to account for reported increases to the vendor's acquisition cost, but not to exceed the ASP+6 percent limit. This means that a 2.1 percent increase would be applied to CAP payment amounts for all HCPCS codes that are in the composite drug list and are being supplied under the CAP by one or more approved CAP vendors. For HCPCS codes that are priced separately, each code available through the CAP will be compared to the most recent ASP+6 percent limit for that code. CAP payment amounts for codes that exceed the ASP+6 percent limit will be reduced to ASP+6 percent. Each ''Not Otherwise Classified'' (NOC) drug described in § 414.906(f)(2)(iv), would also be updated on an individual (rather than composite) basis.

We proposed to discontinue annual CAP payment amount updates and to implement quarterly CAP payment amount updates at § 414.906(c). We also proposed to discontinue the special quarterly adjustments described at § 414.906(c)(2) (for the introduction of new drugs, expiration of drug patents or availability of generic drugs, material shortages, or withdrawal of a drug from the market) and instead to add details about the payment amount update

process described in section II.J.2.f. of this final rule with comment period (Annual CAP Payment Amount Update Mechanism). A quarterly RNAC reporting and payment adjustment process would begin as soon as we enter into contracts with the approved CAP vendor(s); that is, beginning with the first quarter during which CAP claims are submitted under the contract. Thus, we also proposed to eliminate the PPI-based adjustment for the time period between the time bids are submitted and the time claims processing begins under the contract, because that adjustment would no longer be necessary. We believe that using one payment update process will be easier to administer and will minimize the potential for CAP payment amounts to exceed ASP+6 percent for the first contract year. In order to provide sufficient time for the calculation of payment amount updates, we proposed that approved CAP vendors report quarterly RNAC data for drug purchased for use under the CAP during the previous quarter within 30 days of the close of that quarter. We made corresponding changes to regulation text at § 414.906(c) and asked for comments on these proposed changes.

The following is summary of the comments we received regarding the proposed revisions to the frequency of drug payment amount updates under the CAP.

Comment: All commenters agreed with the proposal to implement quarterly updates; however, some commenters were concerned that even quarterly updates would not cover losses that began prior to an update. The response to the ASP+6 percent limit was mixed. Several commenters supported the limit, but several commenters were concerned that payment at ASP+6 percent or less was a financial risk to vendors. Commenters suggested several approaches to further minimize vendors financial risks due to price increases, including a transaction fee to offset the financial risk associated with certain drugs, especially low cost items, the use of varying update percentages, including amounts greater that 6 percent, and product specific (NDC level) adjustments.

Response: We agree with comments that support the quarterly update process and agree that changing to a quarterly payment amount update frequency will benefit approved CAP vendors by reducing financial risk, even though the process is more burdensome than an annual process. The quarterly process will eliminate the need for a PPI based payment amount adjustment at the beginning of a contract period. We appreciate the discussion of risk presented by commenters, but we also believe that it is appropriate to maintain an ASP+6 percent limit for price increases for the reasons stated in our proposal and we note that the lag period between quarterly adjustments will apply to both price increases and price decreases, including situations where generic versions of a drug are introduced. As mentioned in the proposed rule and in previous rules, we continue to believe that the ASP+6 percent ceiling is consistent with our previous policies because it preserves the potential for savings to the program, while providing parity between the CAP and ASP payment systems.

We also believe that the elimination of many low cost items from the drug list, as discussed in the next section, will decrease financial risk and administrative burden for approved CAP vendors, and therefore, we do not believe that transaction fees are necessary or are consistent with the policy to maintain an ASP+6 percent ceiling. Finally, we remind readers that although payment amount updates for the core group of CAP drugs will be done as a group, payment amount updates for drugs added by approved CAP vendor request will continue to be calculated by individual HCPCS code, thereby further minimizing the financial risk associated with the addition of new drugs to the approved CAP vendor's CAP drug list.

Therefore, we are finalizing all of our proposals for this section without change. This includes the discontinuation of the annual payment amount adjustments, the discontinuation of PPI-based increases and the discontinuation of special quarterly payment amount increases described in § 414.906(c). We are also finalizing the implementation of quarterly payment amount increases that begin in the first quarter of the CAP claims contract period, the ASP+6 percent limit on payment amount increases, and all corresponding regulation text changes.

b. Changes to the CAP Drug List

(1) CAP Drug List

In the July 6, 2005 IFC, we responded to comments on our proposed approach for determining the CAP drug categories and how we select the specific drugs in the CAP drug list (70 FR 39026 through 39034). As stated in the CY 2006 PFS final rule with comment period (70 FR 70237), the CAP is intended to provide beneficiaries with access to Medicare Part B drugs and maintain physician flexibility when prescribing medications. Our approach incorporated drugs commonly administered by the range of physician specialties that bill for Part B drugs (70 FR 39030) and resulted in a list of about 180 drugs that were available through the CAP during the CY 2006 through CY 2008 contract period. We also developed a number of methods by which an approved CAP vendor's CAP drug list could be changed (see Table 26 at 70 FR 70242).

We believe that our general approach, to provide a wide variety of drugs to a variety of physicians over a large portion of the United States, is on target. Although we believe that the CAP is a means for physicians to minimize their drug inventory costs, we acknowledge that participation in the CAP cannot completely eliminate the need for participating CAP physicians to maintain at least a minimal drug inventory at the office. Many physicians who participate in Medicare also provide services to non-Medicare patients, and even physicians with a predominantly Medicare patient population may find it useful to keep a small stock of drugs on hand for unforeseen situations, such as emergencies and breakage.

During the CAP postponement, we became aware that both participating CAP physicians and potential vendors supported narrowing the CAP drug list. Both agreed that low cost drugs should be removed from the CAP. Although these items were initially included in the CAP so that an approved CAP vendor would be in a position to supply many of the Part B drugs that an office might administer, CAP physicians and the vendor community have stated that the inclusion of these items in the CAP creates an accounting, tracking, and claims submission burden for some participants. Based on these comments, we believe that low-cost, frequently utilized items, such as corticosteroid injections, could be removed from the list without significant impact on the CAP's utility to participating CAP physicians. Furthermore, it appears that physicians would be more interested in obtaining expensive products, such as biologicals, through the CAP. However, we are also mindful that narrowing the CAP drug list significantly also would decrease an approved CAP vendor's overall purchase volume, and we believe that this could limit the approved CAP vendor's ability to obtain volume-based discounts from the manufacturers or distributors from which it obtains drugs for use in the CAP. Creating a more tailored CAP drug category also could limit physician participation to one or several specialties, and may create a situation

where sudden supply interruptions and unexpected changes to distribution channels could affect a greater proportion of drugs in the program than would be the case with a broader CAP drug category.

We proposed to create a new CAP drug category for the next round of CAP contracting. Our approach is intended to address comments about the administrative burden of tracking and billing low cost/high volume items while maintaining access to a variety of high cost items. We proposed to identify the new CAP drug category using the existing CAP drug category as a starting point. The 2008 CAP drug list was compiled based on Part B drug claims data, the identification of specialties that frequently administer drugs under Part B, and public comment during rulemaking in 2005 (70 FR 39026 through 39033). We believe that using the 2008 CAP drug list as a starting point would maintain prescribing flexibility for a wide range of specialties and would also maintain access to a wide spectrum of drugs that have been utilized under the program previously. Furthermore, we do not believe it is necessary to develop a new approach because the 2008 CAP drug list was based on heavily utilized drugs in Medicare Part B physician practices; we believe that this approach is on target.

We proposed to amend our list based on CAP physician participation, claims data, and comments indicating that the list should be narrowed to higher cost items. First, we ''filtered'' the original CAP drug category (drugs furnished in 2006 through 2009) by the specialties that most frequently prescribe drugs under the CAP, and the highest dollar volume CAP drugs (top 20 percent of allowed charges) compiled from 2008 claims data. This filtered list is the starting point for the updated CAP drug category. However, we acknowledged that a filtering process based on frequency of claims from a subset of physicians who might participate in the CAP cannot fully capture all drugs that may be used by certain specialties. In other words, the filtering steps described above narrow the CAP drug list based on physician specialties and dollar volume and do not necessarily preserve groups of drugs that certain prescribers may utilize, especially the less frequently utilized items in such groups. Therefore, we also proposed to ''fill in'' groups of drugs with related items that do not appear on our list. We stated that we will consider ''filling in'' any drug or biological product that is physician-administered, has a reasonably high utilization in the Medicare population, is related to drugs already in the CAP (for example, because of similar clinical uses), and is otherwise appropriate for inclusion in the program. The concept of ''filling in'' drug groups is supported by feedback from former participating CAP physicians who suggested that certain categories of drugs, such as antibiotics, be more fully represented.

We solicited comments on specific drugs that should be added to the 29 item draft list presented in the proposed rule (Table 35 in the CY 2010 PFS proposed rule (74 FR 33627)), and we also sought comments on the method to assess whether a particular drug should be ''filled in'' so that it is included in the new, narrowed CAP drug category, especially drugs that did not pass the ''filtering'' step described above. We proposed an approach using the 180 item 2009 through 2011 CAP vendor bidding list (See the Downloads section at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/03a_vendorbackground.asp#TopOfPage*) that was used during the approved CAP vendor bidding for the 2009–11 contract. This list includes CMS approved items added to the original contract's bid list, as well as items approved for addition during the 2006–2008 contract period. This list's weighting is based on claims volume data by HCPCS code units rather than dollar volume and provides a different perspective than a dollar volume sorting. We proposed adding drugs from the 2009–2011 CAP Vendor bid list to the CAP drug category if the drug's weight is in the top 25 percent of the 2009–11 CAP vendor bidding list, indicating frequent claims submission, and if the drug's clinical uses are similar to a drug on the 29 item proposed list. This method results in the addition of 12 items, including several commonly used antibiotics, two antiemetics and several chemotherapeutic agents. Although this method helps ''fill in'' the proposed CAP drug list, we stated that this method still does not fully capture less frequently used drugs, or newly approved drugs, and we asked for comments on this method and alternative methods of filling this proposed list.

In order to provide additional flexibility for participating CAP physicians and approved CAP vendors, and to allow for participants to further tailor the program to meet their needs, we also proposed to add § 414.906(f)(2)(v) to allow approved CAP vendors to submit a request to CMS to add drugs (or biologicals) to the list of drugs furnished by the requesting vendor if there is sufficient demand and if the drug has therapeutic uses that are similar to other drugs already available through the CAP. The request and approval process would follow the existing regulations at § 414.906(f), and HCPCS code additions that are requested under this process would still be subject to CMS approval. This process adds to the process for adding newly issued HCPCS codes under § 414.906(f)(2)(iii) and newly approved drugs without HCPCS codes (NOC drugs) under § 414.906(f)(2)(iv). It is intended to facilitate more complete access to groups of drugs that may be used by certain specialties, and drugs used to treat certain disease states without having to rely on rigid definitions of classes of drugs that may not apply well to actual clinical practice across a large and diverse geographic area. We believe that this addition to the methods for changing an approved CAP vendor's drug list (see Table 26 in the CY 2007 PFS final rule with comment period (70 FR 70242)) will add to the flexibility of the program.

The following is summary of the comments we received regarding the proposed revisions the CAP drug list.

Comment: Narrowing the CAP drug list as proposed, particularly removing lower-cost items that are burdensome to track, was supported by numerous commenters, although one commenter pointed out that our revisions could affect participation by infectious disease physicians because of the limited number of antimicrobials. One comment specifically recommended using volume data to create the updated list. Also, commenters supported the concept of filling in drugs based on similar clinical uses. Several commenters requested that the following specific drugs or groups of drugs be added to the final list: Vectibix® (panitumumab); Nplate® (romiplostim); LHRH analogues-specifically leuprolide depot; orphan drugs; and more antibiotics. Several commenters recommended that plasma protein derived drugs and biologicals not be included in the CAP drug list. One commenter recommended that stakeholders other than vendors be allowed to request changes to the drug list.

Response: Based on overall support for a narrowed CAP drug list, we are specifying a 41 item bid list that appears in Table 29. This list includes both the list of drugs that we proposed to include as well as all of the potential additions that we discussed in the proposed rule and this list is the single drug category for the next bidding period. No plasma protein therapies described in comments appear on this list. Plasma protein therapies, including IVIG, clotting factors, and alpha-1 proteinase

inhibitors, have not been furnished under the CAP in the past and therefore would not have been included in the list from which we applied the ''filtering steps'' to develop this drug list. Also in the July 2005 interim final rule with comment (70 FR 39029) we stated that before adding clotting factors or IVIG to the CAP drug list, we would publish a proposed rule and seek public comment. At this time, we are not adding these items to the CAP drug list because we did not specifically propose to do so in the proposed rule.

Although we did not receive any comments that presented a specific and detailed method to further expand or fill in the drug list, the use of volume based filtering and the concept of filling in the drug list was supported by commenters. Thus, as noted above, we are including the potential additions specified in the proposed rule. Further, we are finalizing the proposed approach for approved CAP vendor-requested additions of drugs that have similar uses to drugs on the bid list.

We believe that selecting the larger base drug list and providing a process for approved CAP vendors to request to add drugs that can further ''fill in'' this list strikes a balance between specifying a minimum scope of drugs and biologicals that will be available under the CAP and providing flexibility for the approved CAP vendor to manage the risk associated with providing a broader array of drugs and biologicals. For this reason, we are not adding any other drugs or biologicals to the bid list or creating an addendum to the bid list at this time. We believe that vendors will be interested in expanding groups of drugs and biologicals available under the CAP in order to maximize physician participation and order volume, and that this will tend to increase the number of therapeutically similar items within the drug list.

We disagree with the commenter who requested that parties other than the approved CAP vendor, for example manufacturers, be permitted to request that CMS add drugs to the CAP category. First, we believe this rulemaking has provided an opportunity for the public to provide input on the CAP drug category, so an additional process is unnecessary. Second, we believe it would be imprudent to permit such a process during the CAP contracting period, because we believe it would be inappropriate to force an approved CAP vendor, mid-contract, to supply drugs that it did not initially consider in its bid and that may be financially risky, may require highly specialized handling, or may necessitate participation in specialized purchasing arrangements.

We believe that requiring approved CAP vendors to add products that they did not choose to bid on or subsequently provide may also limit bidders' interest and could limit the number of approved CAP vendors for physicians to choose from, thereby restricting all access to CAP drugs. We will continue with our policy that allows only approved CAP vendors to request changes to the CAP drug list; however, external stakeholders may approach approved CAP vendors to discuss the potential addition of products to an approved CAP vendor's drug list. As noted above, we believe approved CAP vendors would have an incentive to be responsive to such requests. The new mechanism for deleting drugs from the CAP drug list is discussed in the following section.

With respect to the specific drug and biological products mentioned in the comments, we believe that the addition of specific items mentioned in the comments appears to be best suited for addition to the CAP drug list through vendor requests. We have discussed issues pertaining to orphan drugs, leuprolide and drugs similar to leuprolide and in a previous rule (70 FR 70241 and 70 FR 70243, respectively). While we appreciate these suggestions, we are not compelled to add these drugs to the CAP drug list as required items based on these comments. For the reasons stated in our previous rules, we continue to believe it is prudent to continue to omit these drugs from the CAP. Further, because we are not certain of the potential market volume for these drugs in the CAP, we will not add them to the drug list at this time. We are aware that leuprolide and other gonadotropin releasing hormone agonists are commonly used to treat prostate cancer and are highly utilized items in Medicare; however CAP participation by providers that prescribe these drugs has been low. However, we note that triptorelin (J3315), a gonadotropin releasing hormone agonist used in the treatment of prostate cancer is on the CAP drug list, and therefore, the addition of other gonadotropin releasing hormone analogues though the approved CAP vendor process for adding drugs described above and in new regulation text at § 414.908 would be feasible.

Similarly, new drugs such as Vetibix® and some antibiotics, which were on the CAP drug list during the last contract period, but were filtered out during the development of the new drug list, appear to be good candidates for approved CAP vendor-requested additions because agents with similar therapeutic uses are on the drug list. We will not add these drugs to the drug list at this time because we are not certain that these drugs will have sufficient market volume in the CAP. We also note that one item, Nplate®, an orphan drug only available through a single specialty vendor, and with limited use potential in the Medicare population, also appears to be a candidate for addition upon approved CAP vendor request. As discussed above, we are seeking to balance physician access and approved CAP vendor risk related to the drug list. In light of the lack of widespread demand for such drugs to be included in the CAP drug list (and thus available from all approved CAP vendors), we believe that permitting approved CAP vendors to request to supply those drugs, but not requiring them to do so, strikes the appropriate balance.

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TABLE 29: Finalized CAP Single Drug Category List for the Next Contract Period

Code	Procedure Code Description
J0129	INJECTION, ABATACEPT, 10 MG
J0215	INJECTION, ALEFACEPT, 0.5 MG
J0585	BOTULINUM TOXIN TYPE A, PER UNIT
J0587	BOTULINUM TOXIN TYPE B, PER 100 UNITS
J0696	INJECTION, CEFTRIAXONE SODIUM, PER 250 MG
J0878	DAPTOMYCIN INJECTION, 1 MG
J0881	INJECTION, DARBEPOETIN ALFA, 1 MCG (NON-ESRD USE)
J0885	INJECTION, EPOETIN ALPHA, (FOR NON ESRD USE), PER 1000 UNITS
J0894	INJECTION, DECITABINE, 1MG
J1440	INJECTION, FILGRASTIM (G-CSF), 300 MCG
J1441	INJECTION, FILGRASTIM (G-CSF), 480 MCG
J1740	INJECTION, IBANDRONATE SODIUM, 1 MG
J1745	INJECTION INFLIXIMAB, 10 MG
J2323	INJECTION, NATALIZUMAB, 1 MG
J2353	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG
J2357	OMALIZUMAB INJECTION, 5 MG
J2405	INJECTION, ONDANSETRON HYDROCHLORIDE, PER 1 MG
J2469	PALONOSETRON HCL, 25MCG
J2503	PEGAPTANIB, 0.3MG
J2505	INJECTION, PEGFILGRASTIM, 6 MG
J2778	INJECTION, RANIBIZUMAB, 0.1 MG
J2794	RISPERIDONE, LONG ACTING, 0.5MG
J3240	INJECTION, THYROTROPIN ALPHA, 0.9 MG, PROVIDED IN 1.1 MG VIAL
J3315	INJECTION, TRIPTORELIN PAMOATE, 3.75 MG
J3396	INJECTION, VERTEPORFIN, 0.1 MG
J3487	INJECTION, ZOLEDRONIC ACID, 1 MG
J3488	INJECTION, ZOLEDRONIC ACID (RECLAST), 1 MG
J7321	HYALURONAN OR DERIVATIVE, HYALGAN OR SUPARTZ, FOR INTRA-ARTICULAR INJECTION, Per Dose
J7322	HYALURONAN OR DERIVATIVE, SYNVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
J7324	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
J9010	ALEMTUZUMAB, 10 MG

Code	Procedure Code Description
J9035	BEVACIZUMAB INJECTION, 10MG
J9041	BORTEZOMIB INJECTION, 0.1MG
J9055	CETUXIMAB INJECTION, 10MG
J9170	DOCETAXEL, 20 MG
J9201	GEMCITABINE HCL, 200 MG
J9206	IRINOTECAN, 20 MG
J9263	INJECTION, OXALIPLATIN, 0.5 MG
J9305	PEMETREXED INJECTION, 10MG
J9310	RITUXIMAB, 100 MG
J9355	TRASTUZUMAB, 10 MG
J3370	INJECTION, VANCOMYCIN HCL, 500 MG
J9264	PACLITAXEL PROTEIN BOUND PARTICLES, 1MG
J0690	INJECTION, CEFAZOLIN SODIUM, 500 MG
J1260	INJECTION, DOLASETRON MESYLATE, 10 MG
J0692	INJECTION, CEFEPIME HYDROCHLORIDE, 500 MG
J1626	INJECTION, GRANISETRON HYDROCHLORIDE, 100 MCG
J0640	INJECTION, LEUCOVORIN CALCIUM, PER 50 MG
J9265	PACLITAXEL, 30 MG
J9190	FLUOROURACIL, 500 MG
J9045	CARBOPLATIN, 50 MG
J0290	INJECTION, AMPICILLIN SODIUM, 500 MG
J9214	INTERFERON, ALFA-2B, RECOMBINANT, 1 MILLION UNITS

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2. Removing Drugs From the CAP List

Although there are several methods under the CAP to add drugs to an approved CAP vendor's drug list, the current regulations do not specify a process for removing drugs from an approved CAP vendor's list. Our experience has shown that interruptions in availability can affect an approved CAP vendor's ability to supply CAP drugs during the course of a 3-year contract. For example, during the first contract period, we became aware of long-term and permanent drug unavailability, sometimes at the HCPCS level, due to removal of drugs from the market, or interruption of supply to an approved CAP vendor for reasons beyond the approved CAP vendor's control, such as changes to drug distribution methods, changes in agreements between manufacturers and distributors and/or pharmacies regarding who may purchase certain drugs, and direct distribution arrangements.

In order to better respond to sudden, long-term changes in drug supply that are beyond the control of the approved CAP vendor, we proposed to allow an approved CAP vendor to request the permanent removal from its CAP drug list of a HCPCS code for which no NDCs are available. Our proposal is intended to better manage situations where all NDCs from an entire HCPCS code unexpectedly become unavailable to an approved CAP vendor, and we would require the approved CAP vendor: (1) to document the situation in writing, including the unavailability of all NDC codes in a HCPCS code that is supplied under the CAP; (2) to describe the reason for the unavailability and its anticipated duration; and (3) to attest that the unavailability is beyond the approved CAP vendor's control. Approval of the deletion would apply only to the approved CAP vendor or vendors that requested the deletion. Our proposal was not intended to be used frequently, or to permit an approved CAP vendor to remove a HCPCS code from its CAP drug list simply because it has become unprofitable to provide it—we believe the payment amount adjustment proposals discussed in sections II.J.2.a. and f. of this final rule addresses that concern. Furthermore, our proposal was also not intended to be used for managing short-term unavailability, or unavailability of a finite duration—we believe the existing drug substitution policy described in § 414.906(f) already addresses those concerns. We proposed to add this process as § 414.906(g) because those regulations currently provide for additions and substitutions to the CAP drug list, and would therefore require a

written request to CMS, as well as CMS' approval.

Participating CAP physicians who are affected by the deletion of a HCPCS code from an approved CAP vendor's drug list would have the option of remaining with their selected approved CAP vendor and using the ASP (buy and bill) methodology for obtaining the drug that has been deleted, or selecting another approved CAP vendor under the exigent circumstances provision at § 414.908(a)(2). We believe that the deletion of an expensive and highly utilized CAP drug by one approved CAP vendor in the middle of a physician election period could cause hardship for a practice if it had to revert to the ASP methodology of acquiring and billing for that drug. Such a situation would constitute an exigent circumstance. Given CAP's goal of improving access to drugs, allowing the participating CAP physician to switch approved CAP vendors outside of a regular election period in this instance would be prudent.

The following is summary of the comments we received regarding the proposed method to remove items from an approved CAP vendor's drug list.

Comment: Comments supported a mechanism to delete unavailable drugs from vendors' lists and also supported allowing physicians affected by the deletion of a HCPCS to have an opportunity to obtain the drug through the ASP process or to select another vendor. One commenter asked for well-defined standards for removing a drug from the list.

Response: Based on support for our proposal in the comments, we are finalizing the proposed process where an approved CAP vendor may request the permanent removal from its CAP drug list of a HCPCS code for which no NDCs are available. Participating CAP physicians affected by such a deletion will be able to obtain the deleted drug under the ASP methodology, or will be able to switch approved CAP vendors outside of the regular physician election process under the exigent circumstance provision.

We believe that the preamble text provides sufficiently detailed guidance about the process. Specifically, we require the approved CAP vendor: (1) to document the situation in writing, including the unavailability of all NDC codes in a HCPCS code that is supplied under the CAP; (2) to describe the reason for the unavailability and its anticipated duration; and (3) to attest that the unavailability is beyond the approved CAP vendor's control. By way of example only, situations that create unavailability beyond the vendor's control could include: FDA action to remove a drug from the market, long-term unavailability of specialized raw materials or long-term manufacturing delays, and changes in distribution arrangements that prevent the approved CAP vendor from buying or supplying the drug within CAP requirements. CMS will assess the information provided by the vendor and approve such requests as described in regulation text at § 414.908(f)(3) and (4).

This process is intended to provide the approved CAP vendor with flexibility to respond to long-term drug supply issues, however, this process is not intended to be used frequently, or to permit an approved CAP vendor to remove a HCPCS code from its CAP drug list simply because it has become unprofitable to provide it, and this process is not intended to be used for managing short-term unavailability, or unavailability of a finite duration.

c. Geographic Area Served by the CAP

In the July 6, 2005 IFC (70 FR 39034 through 39036), we established a single, national competitive acquisition area for the initial stage of the CAP. This national distribution area included the 50 States, the District of Columbia, Puerto Rico, and U.S. territories. We recognized that designating a single national area might limit participation to those vendors that could compete to bid and supply drugs nationally, but we indicated this approach was a part of the phase-in plan for the CAP. We also discussed potential phase-in options for the future, stating that smaller areas might become a solution as the program expanded.

According to the vendor community, certain areas of the United States (especially Alaska, Hawaii, and the Territories) currently present logistical challenges and are associated with high drug shipping costs. Moreover, physician participation in these areas has been low; in 2008, physicians from Alaska, Hawaii, and the Territories represented less than 2 percent of total participating CAP physicians. Temporarily limiting the geographic areas served by the CAP could help limit costs and risks for approved CAP vendors associated with shipping drugs to distant parts of the country. However, we believe that the CAP is intended to provide services to all Medicare physicians (including those in distant parts of the country), and therefore, we do not believe that a limitation on the geographic area in which the CAP is available should be permanent.

Section 1847B(a)(1)(B) of the Act specifically requires the Secretary to phase-in the CAP with respect to the categories of drugs and biologicals in the program, in such a manner as the Secretary determines to be appropriate. We believe that this provision, particularly in conjunction with the statutory definition of a competitive acquisition area as ''an appropriate geographic region established by the Secretary'' provides broad authority for the Secretary to phase in the CAP with respect to the geographical areas in which the program would be implemented. As stated in the July 6, 2005 IFC, we considered several factors when defining geographic areas for the CAP, including aspects of vendors and their distribution systems, such as current geographic service areas, the density of distribution centers, the distances drugs and biologicals are typically shipped, and costs associated with shipping and handling (70 FR 39035). Taking these factors into consideration again, and considering entities who have bid on, or expressed interest in bidding on approved CAP vendor contracts, we believe that it is appropriate to use the authority granted under the Statute to temporarily narrow the area served by the CAP during the program's re-implementation. We appreciate the logistical issues associated with shipping drugs to remote areas and the uncertainties associated with transportation costs that have been described by the potential vendor community; however, we are reluctant to significantly reduce the area served by the CAP because at some point, the approved CAP vendor's volume would be affected and the likelihood of obtaining volume based discounts would decrease.

In the current proposed rule, we proposed to designate the CAP competitive acquisition area as the 48 contiguous States and the District of Columbia for the next round of CAP contracting. This change in the geographic area that is served by the CAP is meant as an interim measure under our phase-in authority and the statutory definition of a competitive acquisition area. We believe that omitting Alaska, Hawaii, and the Territories from the CAP competitive acquisition area at this time will balance the need to revise the CAP to attract more vendors with the need to offer the maximum number of physicians a meaningful opportunity to participate. We believe that the proposal will encourage potential vendors to participate in the CAP because it would temporarily omit areas associated with low physician participation, long shipping times, and high shipping costs. Furthermore, this measure is unlikely to

significantly decrease CAP drug order volume relative to historical physician participation in the CAP. However, we are aware that our proposal temporarily eliminates the CAP option for physicians in the areas not included in this CAP competitive acquisition area. Therefore, we did not propose this definition of the CAP geographical area as a permanent solution.

The following is summary of the comments we received regarding the proposed to revisions the geographic area serviced by the CAP.

Comment: Commenters supported the proposal; one commenter recommended a more limited approach using smaller areas and selected physician specialties.

Response: Based on comments supporting our proposal, we are finalizing the proposal to temporarily limit the CAP geographic area to the 48 contiguous States and the District of Columbia for the next bidding period. We do not believe that a smaller geographic area is desirable or necessary. Overnight shipping is available over much of the proposed area and we are concerned about further limiting access to the CAP.

As suggested in comments and discussed in the proposed rule, we will continue to assess the CAP and update plans for phase in activity in future rulemaking efforts, including determining the circumstances under which CAP participation will be offered to physicians in Alaska, Hawaii, and the Territories. We will also continue to consider modifying the definition of competitive acquisition area on the basis of regions, States, or some smaller geographic area, which might expand the number of vendors that could bid to participate in the program.

d. CAP Drug Stock at the Physician's Office

Our discussion about the CAP emergency restocking option in the July 6, 2005 IFC indicated that a participating CAP physician could not maintain a stock of an approved CAP vendor's drug in his or her inventory. This was done because we had reservations about potential program integrity and drug diversion issues (70 FR 39047).

Since that time, we have gained operational experience with the CAP and a better understanding of the ordering and drug delivery process. We have also received additional public feedback about the different ways that the program could be refined, and we have not received any negative feedback from the vendor community indicating a concern about storing CAP drugs in physicians' offices. Therefore, we believe at this time it is appropriate to consider allowing additional flexibility to encourage CAP participation.

Our experience with the CAP, and our increased understanding about the options approved CAP vendors might have for furnishing drugs to a participating CAP physician's office also support considering additional flexibility in this area. For example, we are aware of electronic inventory control and charge capture devices that could be utilized in ways that conform to CAP regulations and are compliant with applicable State and Federal laws. Such devices utilize an electronic transaction based on a physician's order to track the administration of drugs from inventory to a specific patient and to document appropriate charges for the drug. We believe that such systems could fit into the current CAP framework when transactions in such systems are based on a physician's order, because such systems can track inventory, and can be used to capture patient charge data.

For these reasons, we proposed to allow approved CAP vendors to utilize electronic transactions to furnish CAP drugs from nominal quantities of approved CAP vendor-owned stock located at the physician's office in response to specific prescription orders and to capture charges related to such transactions. The proposal was also intended to clarify that entities with alternative approaches to supplying drugs that utilize an electronic transaction are welcome to participate in the CAP bidding process. We believe that this will allow for additional flexibility and efficiency in the ordering and delivery of drugs within the program because it allows for more efficient shipping of approved CAP vendor-owned stock and provides the option of CAP participation for physicians who use or may choose to use such drug inventory management platforms. The proposal did not change our position that a participating CAP physician shall not take title to or pay for CAP drugs, nor does it alter the requirements for information that must be submitted with a prescription order under § 414.908(a) or the application of HIPAA to such data.

Furthermore, the proposal does not affect the applicability of State licensing requirements for an approved CAP vendor. As stated in the July 6, 2005 IFC (70 FR 39066), either the approved CAP vendor, its subcontractor under the CAP, or both, must be licensed appropriately by each State to conduct its operations under the CAP. Therefore, if a State requires it, an approved CAP vendor would be required to be licensed as a pharmacy, as well as a distributor. We did not propose to revise the requirements at § 414.908(c) and § 414.914(f)(9), and we noted that sections 1847B(b)(6) and 1847B(b)(2)(B) of the Act continue to apply. In order to participate in the CAP successful bidders must continue to submit proof of pharmacy licensure, consistent with applicable State requirements.

Also, we stated that the proposal would not modify our definition of ''emergency delivery'' or its corresponding requirements at § 414.902. As we stated in our July 6, 2005 IFC, the intent of the 1-business-day timeframe for emergency deliveries is to address the participating CAP physician's need for more rapid delivery of drugs in certain clinical situations with the approved CAP vendor's ability to ship the drug and have it delivered promptly in a nationwide delivery area (70 FR 39045). The emergency delivery timeframe still applies in situations when CAP drugs are not available in the office for electronic delivery.

Moreover, the proposal did not seek to change the CAP inventory requirements. CAP drugs belong to the approved CAP vendor, and as indicated in the July 6, 2005 IFC (70 FR 39048), participating CAP physicians are required to maintain a separate electronic or paper inventory for each CAP drug obtained. CAP drugs must be tracked separately in some way (for example, an electronic spreadsheet). CAP drugs do not have to be stored separately from a physician's own stock; that is, co-mingling of CAP drug with drug from a participating CAP physician's own private stock is acceptable as long as a record of approved CAP vendor-owned drug is kept in a manner that is consistent with § 414.908(a)(3)(x) and the approved CAP vendor-owned drug can be accounted for, as needed.

Also, the proposal did not affect the CAP emergency restocking requirements. Section 1847B(b)(5) of the Act and § 414.906(e) provide criteria for the replacement of drugs taken from a participating CAP physician's inventory in the event of an emergency situation. When the emergency resupply criteria are met, a participating CAP physician can replace the drugs that were used from his or her own inventory by submitting a prescription order to the approved CAP vendor.

The proposal sought to clarify the potential approaches that a bidder may use (separately or in combination) to supply drugs under the CAP and did not seek to specify a particular approach that bidders must use in future responses to CAP bid solicitations or to strictly define the types of entities that

could bid on CAP vendor contracts; for example, whether bidders must be pharmacies, drug distributors, or a hybrid of the two; whether bidders must utilize just in time shipping, or electronic inventory transactions to supply CAP drugs. We stated that we will consider approving bidders' approaches that are consistent with the statutory framework, applicable laws, and regulations.

The following is a summary of the comments we received regarding CAP drug stock at the participating CAP physician's office.

Comment: Most commenters supported the concept of electronic transactions in the CAP drug supply process. However, a few commenters appear to have misunderstood our proposal as authorizing a CAP vendor to store unlimited amounts of stock in a physician's office. Some commenters also requested details about the types of systems we will accept, how these systems could work in smaller offices, and some commenters were concerned about how appropriate or ''nominal'' stock levels would be defined.

Response: The comments lead us to believe that we need to clarify our proposal. We proposed to allow approved CAP vendors to utilize electronic transactions to furnish CAP drugs from nominal quantities of approved CAP vendor-owned stock located at the physician's office in response to specific prescription orders and to capture charges related to such transactions. This proposal is primarily intended to work with automated cabinets that provide controlled access to drugs and was intended to make clear that entities using electronic inventory devices were welcome to participate in the CAP. However, we are not requiring that these specific devices be used in conjunction with nominal amounts of vendor owned office stock or requiring any specific types of devices, hardware, or software.

Instead, we are providing a framework under which certain quantities of vendor-owned CAP drug stock may be located in a participating CAP physician's office and delivered in conjunction with electronic transactions and charge capture. An electronic transaction may be used to communicate the fact that participating CAP physician is submitting a prescription order for a CAP drug and, on the basis of that prescription order, the drug is being delivered to the participating CAP physician from the nominal amount of vendor-owned stock at the office for administration to a beneficiary. Once the approved CAP vendor receives the prescription order it may bill for the drug in accordance with existing rules. Corresponding documentation of drug administration in the medical record is still required for meeting post-payment review requirements to establish that the drug has been administered to a beneficiary and is thus eligible for payment under section 1847B(a)(3)(D) of the Act.

This process is intended to work with CAP inventory requirements in § 414.906(e) and § 414.908(a), and can also work with office stock models that utilize periodic shipment of stock to maintain predetermined levels. In such systems, periodic shipments of regularly used amounts of items are made, for example, weekly. The shipped amounts are based on average amounts used over the time period between shipments, but may be modified as necessary to accommodate for actual use.

We agree with commenters that we should provide further information about what we would consider to be a ''nominal'' level of vendor-owned stock. Therefore, we are clarifying that that ''nominal quantities of stock'' means quantities that do not exceed what is typically used by the participating CAP physician's office between the approved CAP vendor shipment periods. We are not specifying what the shipment periods must be, however, we would like to point out that we do not intend this process to mean that large quantities of CAP drug would be kept at a physician's office.

We also remind readers that CAP drug stock remains the property of the approved CAP vendor, and that participating CAP physicians do not take title to CAP drug stock or make any payment for drugs that furnished and administered under the CAP. CAP drugs must be stored in a manner that is consistent with applicable law and regulations, as well as product integrity and handling requirements.

Comment: One commenter understood the proposal to mean that physician-owned stock supplied by entities other than the approved CAP vendor may be used for the CAP. Another commenter encouraged a mechanism to reassign physician-owned stock for the CAP.

Response: CAP drugs remain the property of the approved CAP vendor until they are administered to a beneficiary, at which time billing for the drug by the approved CAP vendor may take place. Under our emergency restocking provisions (described in further detail below), drugs purchased by the participating CAP physician's office for its own drug inventory may be used instead of approved CAP vendor inventory in certain situations, and then the approved CAP vendor may supply a replacement.

However, we do not believe that the physician's office stock, that is, drugs bought by the physician's office, should be used as a primary source of drugs for the CAP because such a structure is inconsistent with the CAP program as set forth in section 1847B of the Act, which clearly contemplates that the approved CAP vendor supply CAP drugs to the participating CAP physician rather than merely just bill for drugs that the participating CAP physician already owns. Furthermore, the CAP is an alternative to the ASP or buy and bill process of obtaining drugs administered incident to a physicians' services, and under the CAP as we have implemented it, participating CAP physicians do not take title to or make any payment for drugs furnished under the CAP.

In situations where an approved CAP vendor maintains a certain nominal amount of drugs in a participating CAP physician's office, as discussed above, we anticipate that at certain times a prescription order for an unusual drug or an unexpectedly great demand may result in a situation where the approved CAP vendor's stock is not immediately available in the participating CAP physician's office. In such situations, the approved CAP vendor must ship the drug under the timeframe definitions at § 414.902.

In cases where the drug cannot be delivered in time to meet a clinical need, a participating CAP physician is permitted to use the practice's own inventory and obtain replacement inventory from the approved CAP vendor under § 414.906(e) if all of the following requirements are met: (1) The drugs are required immediately; (2) The participating CAP physician could not have anticipated the need for the drugs; and (3) The approved CAP vendor could not have delivered the drugs in a timely manner, as defined in § 414.902.

This provision is intended for clinical emergencies if a CAP drug is not available from the approved CAP vendor in time. Additional information about the emergency restocking provision appears in the July 6, 2005 interim final rule with comment (70 FR 39047). The physician will be expected to maintain documentation in the patient's medical record to verify that he or she complied with the criteria governing the resupply provision.

Comment: Commenters also suggested periodic inventory reconciliation between approved CAP vendors and participating CAP physicians to accurately track the actual amount of

vendor-owned drug in a physician's inventory.

Response: We believe that the method and the frequency with which an approved CAP vendor may want to account for nominal CAP drug stock at the physician's office will vary based on the cost and handling requirements of the drugs, quantities of drug at the offices, and the approved CAP vendor's experience with the practice. The role of special agreements between approved CAP vendors and participating CAP physicians was discussed in the July 2005 IFC (70 FR 39050).

We believe that details associated with inventory reconciliation, such as the frequency that the process is carried out, whether a vendor's representative would visit the location, etc., could be arranged under such an agreement. However, parties to such arrangements must ensure that the arrangements do not violate the physician self-referral (''Stark'') prohibition (section 1877 of the Act), the Federal anti-kickback statute (section 1128B(b) of the Act), or any other Federal or State law or regulation governing billing or claims submission.

Comment: Commenters also requested clarification about whether CAP is a pharmacy- or distribution-based program and recommended that CMS specify one model in order to decrease vendor risk. One commenter recommended that the CAP be a distribution model in order to capture efficiencies.

Response: We appreciate the comments that suggested we consider our overall approach to the CAP. We have not specified whether the CAP must follow a distribution or a pharmacy model, or a combination, in previous rules. We believe that leaving the option open will maximize the number of bidders and will encourage a variety of approaches for supplying CAP drugs. Given the wide geographic area that the program covers and the diverse Medicare physician population, we also do not want to discourage bidders from developing novel or combined approaches to supplying CAP drugs. Although we acknowledge that vendor interest in the program has been limited, we believe that leaving these options open will benefit the program in the long run by allowing a variety of approaches to supplying drugs under the CAP. Choices between approved CAP vendors with different models will encourage physician interest and are more likely to serve a varied physician population, including large and small offices. We also do not want to unduly limit the types of subcontracting relationships that a bidding entity may develop to supply CAP drugs across a geographic area, particularly in light of the diversity of State laws and regulations, which may change over time.

Comment: One commenter asked whether the bidding documents would contain more detail about licensing requirements.

Response: We acknowledge the comment that suggested the licensing expectations be more clearly described at the time bids are announced. At this time, we will continue to require that an approved CAP vendor must be appropriately licensed in all States.

Comment: One commenter asked about a limited bid involving automation.

Response: This rule did not propose changes to the bidding process, and therefore, we are not making any changes to the bidding process at this time.

e. Exclusion of CAP Sales From ASP Calculations

In response to the March 4, 2005 proposed rule, many commenters requested clarification about whether the prices determined under the CAP will be taken into account in computing the ASP under section 1847A of the Act. In the July 6, 2005 IFC, we responded that prices offered under the CAP must be included in ASP calculations (70 FR 39077). This was done because we initially believed that we did not have the statutory authority to exclude prices determined under the CAP from the computation of ASP under section 1847A of the Act. Section 1847A(c)(2) of the Act contains a specific list of sales that are exempt from the ASP calculation, and sales to approved CAP vendors operating under CAP are not included on that list (70 FR 39077). Comments received in response to the July 6, 2005 IFC opposed this policy (70 FR 70479).

Ultimately, as stated in the November 21, 2005 IFC, we recognized commenters' concerns about the effect of including CAP prices in the calculation of ASP and agreed that the best outcome for both the ASP methodology and the CAP programs would be one in which prices under CAP did not affect payment amounts under the ASP methodology. In particular, we found compelling arguments from commenters about the separation of the ASP and CAP programs and that the two programs are intended to be alternatives to each other. Therefore, we excluded units of CAP drugs that are administered to beneficiaries by participating CAP physicians from the ASP calculation for the initial 3-year approved CAP vendor contract period (70 FR 70479). Accordingly, the definition of ''Unit'' at § 414.802 was also revised to reflect this exclusion.

In our August 18, 2006 interim final rule, we further addressed concerns pertaining to our definition of Unit. We published a PRA notice regarding a proposed modification of the OMB-approved ASP information collection requirements (CMS Form 10110 (OMB #0938–0921)) about the collection of the number of CAP units excluded from the ASP calculation. In response, a commenter expressed concern over manufacturers' reliance on approved CAP vendors for information about the number of units of CAP drugs that are administered to beneficiaries by participating CAP physicians (71 FR 48132). Since approved CAP vendors are the only entities with direct information on CAP units administered, the commenter believed that the requirement to exclude units of CAP drugs administered to beneficiaries by participating CAP physicians placed the manufacturer in the untenable position of reporting ASP and certifying reports of ASP based on second-hand information from approved CAP vendors. Further, the commenter noted that manufacturers may not have timely access to this information and that they could not independently confirm its accuracy (71 FR 48132). Additional feedback received as part of our ongoing work with manufacturers also indicated that they were concerned that they would have difficulty obtaining information from approved CAP vendors that would be necessary to accurately exclude administered CAP units from the ASP calculation (71 FR 48132).

Therefore, we further revised the definition of unit to clarify that for the initial 3-year contract period under the CAP units of CAP drugs sold to an approved CAP vendor for use under the CAP would be excluded from the calculation of ASP (70 FR 48132).

In the July 6, 2005 and August 18, 2006 IFCs, we stated that we would examine the effect of this exclusion and, if necessary, revisit our decision at the end of the initial 3-year period of the CAP (70 FR 70480 and 71 FR 48132, respectively).

Since then, operational experience has not indicated a reason for changing our policy of excluding CAP units sold to approved CAP vendors for use under the CAP from ASP calculations. Therefore, in the current proposed rule, we proposed to permanently exclude drugs supplied under the CAP from ASP calculations and make conforming

changes to the definition of unit at § 414.802. We stated that we believe that the proposal will continue to promote the separation and independence of the two drug payment models.

The following is a summary of the comments we received regarding the proposed revisions to the exclusion of CAP sales from ASP calculations.

Comment: All comments supported permanent exclusion of CAP Sales from ASP calculations.

Response: As a result of the comments, we are finalizing the proposal to permanently exclude CAP Sales from ASP calculations.

f. Annual CAP Payment Amount Update Mechanism

In the July 6, 2005 IFC (70 FR 39076), we described a two-step process to calculate RNAC-based price adjustment if there is a change in the RNAC reported by a particular approved CAP vendor. We stated that ''we would adjust the bid price that the vendor originally submitted by the percentage change indicated in the cost information that the vendor disclosed. Next, we would recompute the single price for the drug as the median of all of these adjusted bid prices.'' The two-step process contemplated that there would be more than one approved CAP vendor at the time prices were to be adjusted and that all successful bidders would participate in the CAP.

However, during the first round of CAP contracting, after offering more than one contract, we entered into a contract with only one successful bidder. Thus, during the 2008 price update calculation process, we developed an approach to account for the lack of RNAC data for bidders who chose not to participate in the CAP. In the CY 2009 PFS proposed rule, we stated that the approach we used to adjust prices for the 2008 contract year is consistent with § 414.906(c) and with the July 6, 2005 IFC because it retains a two-step calculation based on the approved CAP vendor's RNAC, as well as the calculation of a median of adjusted bid prices.

We also posted our approach on the Approved CAP Vendor page of the CMS CAP Web site at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp.* The percent change in RNAC for 2008 was calculated based on data supplied by the approved CAP vendor. This percent change in RNAC was used as a proxy for the percent change in RNAC for successful bidders that chose not to become approved CAP vendors.

Then, in the CY 2009 PFS proposed rule (73 FR 38522 through 38523), we proposed to continue using this approach for future CAP payment amount updates where the number of approved CAP vendors is less than the number of successful bidders. We proposed that the average of the approved CAP vendor-supplied RNAC data would be used as a proxy for data from vendors who bid successfully but are not participating in the CAP. For example, if the payment amounts for the first year of a CAP contract are based on five successful bidders, but only four have signed contracts to supply drugs under the CAP (that is, there are four approved CAP vendors), only RNAC data collected from the four approved CAP vendors would be used to calculate the percent change in the RNAC. The average of the four approved CAP vendors' adjusted payment amounts would be used as a proxy for the RNAC of the successful bidder that is not participating in the CAP. The updated CAP payment amount would then be calculated as the median of the five data points (one data point for each approved CAP vendor's updated payment amount, and one data point calculated using the average of the approved CAP vendors' RNAC). Similarly, if there were five successful bidders but only three chose to become approved CAP vendors, the average of the three approved CAP vendors' RNAC would be the proxy for the RNAC of the two bidders who did not participate. The median of those five data points would become the updated CAP payment amount.

Our approach in the CY 2009 PFS proposed rule was intended to provide us with a flexible method for updating CAP prices, to be consistent with our original policy as stated in the July 6, 2005 IFC, and to account for bidders or approved CAP vendors who are not participating in the program at the time the price updates are calculated. However, our approach was limited in scope because it was made during a contract period and during bidding for an upcoming contract and we did not want to make any significant changes to the CAP program which could affect contractual obligations. Furthermore, we received a comment in response to the CY 2009 PFS proposed rule that suggested the elimination of the proxy procedure so that payments would be based on actual data from participating vendors and would better reflect experience within the program.

After additional consideration, we believe that it would be prudent to simplify and update our 2009 proposal in order to account for successful bidders who choose not to participate in the CAP, possible changes in the number of approved CAP vendors over the life of a 3-year CAP contract, and to allow for flexibility in setting the frequency of payment amount adjustments as described in section II.J.2.a. above. We believe that our updated proposal is easier for the vendor community to understand and for us to implement. Furthermore, our revised proposal is not constrained by concerns about the impact of changes on an active contract.

We proposed to clarify that the RNAC-based adjustment calculations are intended to apply only to approved CAP vendors (not all bidders), and that the most recent previous CAP payment amount (for example, the previous year's or the previous quarter's payment amount) will be the starting point for making the subsequent period's adjustment. Simply put, we proposed to eliminate the use of proxy data for bidders that are no longer participating in the program. Instead, we proposed to use RNAC data only from approved CAP vendors that are participating in the CAP at the time that an RNAC-based price update is being calculated. We also proposed to clarify that the starting point for the payment amount adjustment is the most recent payment amount. The percent change calculated from each participating approved CAP vendor's RNAC data will be applied to the most recent payment amount by recomputing the single price using the median of all participating vendors' adjusted prices.

For example, if quarterly adjustments beginning at the start of claims processing approved CAP vendor's contract as described in section a. above are implemented, and the post bid period's CAP payment amounts are calculated based on five successful bids, but only four approved CAP vendors are participating when CAP claims processing begins, the RNAC-based payment amount adjustment for the first quarter of CAP claims would be based on RNAC data provided by the four approved CAP vendors that will be furnishing drugs under the CAP. The four approved CAP vendors would be required to submit a quarter of RNAC data within thirty days of the close of the quarter to which the data applied, prior to the beginning of CAP claims processing for the new contract. We would apply the percentage change in RNAC reported by each of the four approved CAP vendors to the CAP payment amounts calculated from successful bids, and the adjusted payment amount would be the median of those four adjusted amounts. Assuming that these four vendors are

still furnishing drugs during the second quarter, calculations for the second quarter would apply the RNAC-based adjustment calculated from the four vendors' data to the first quarter's payment amount. That is, the payment amounts for the second quarter would be calculated from the first quarter's payment amounts, adjusted by RNAC data.

This process would apply to the composite bid drug list as amended by rulemaking, meaning that a single weighted percent change in RNAC is calculated for all drugs in the composite bid list (also referred to as the single drug category) and that single percent change is applied to all drugs in the list. For drugs that are bid as separate line items, such as drugs that were included in addendum B of the 2006 bidding period (see 70 FR 39072 and updated as addendum G in 70 FR 70238), or for drugs that are added during a contract period, each HCPCS code will be adjusted as a separate line item. Such codes will not be included in the composite, weighted drug list. Our process will continue to assign a single payment amount to all approved CAP vendors that supply a given HCPCS code; we do not intend to have more than one payment amount for any HCPCS code under the CAP or for individual ''NOC'' drugs described in § 414.906(f)(2)(iv).

This updated approach is flexible, and we believe it can accommodate a variety of scenarios, including a changing number of approved CAP vendors and changes to the frequency with which payment amount updates are made. It provides a straightforward and accurate clarification of the price adjustment mechanism described in regulation text. We believe that this proposal remains consistent with our original preamble language and with our CY 2009 PFS proposal, because it retains the two-step calculation using the percent change in RNAC. Finally, we believe that our approach will eliminate any perception that nonparticipating vendors can significantly affect CAP payment amount adjustments.

The following is summary of the comments we received regarding the proposed to revisions to the annual CAP payment amount update mechanism.

Comment: Comments about CAP price updates focused on the quarterly update frequency. We did not receive any comments that specifically discussed the proposed refinements to our approach, although one commenter recommended caution when using a single update percentage across a large group of drugs because this may increase vendors' financial risk, and suggested product level updates.

Response: We are finalizing the proposal to simplify the update calculation process. Although no comments directly mentioned this proposal, we believe that the updated approach will simplify the calculation process.

We appreciate the comment that suggested that price updates be done at the product or NDC level. However, bidding and payment for drugs furnished under the CAP is made at the HCPCS level. We believe that the smaller single drug category list finalized in section II.J.2.b will decrease the risk associated with applying a single percentage update over a group of drugs, and we also note that drugs added during the CAP contract period through a CMS approved vendor request and drugs that are separately bid will continue to be updated at the individual HCPCS level.

g. 2009 PFS Proposals

(1) Definition of a CAP Physician

In the July 6, 2005 IFC, we stated that section 1847B of the Act most closely describes a system for the provision of and the payment for drugs provided incident to a physician's service (70 FR 39026). In the November 21, 2005 IFC (70 FR 70258), we stated that for the purposes of the CAP, a physician includes all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act. This definition includes doctors of medicine, osteopathy, dental surgery, dental medicine, podiatry, and optometry, as well as chiropractors. However, this definition does not include other health care professionals, such as nurse practitioners (NPs), clinical nurse specialists (CNSs), and other professions such as physician assistants (PAs) who may be able to legally prescribe medications and enroll in Medicare.

In the CY 2009 PFS proposed rule (73 FR 38523), we proposed to further clarify that, for the purposes of the CAP, the definition of a physician included all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act, as well as practitioners (such as NPs, CNSs and PAs) described in section 1861(s)(2)(K) of the Act and other practitioners who legally prescribe drugs associated with services under section 1861(s) of the Act if those services and the associated drugs are covered when furnished incident to a physician's service. While we believed that most practitioners described in section 1861(s)(2)(K) of the Act would bill under specific physician provider numbers, it was not our intent to exclude practitioners who are able to bill independently for drugs associated with services that are covered when provided by a physician and legally authorized to be performed.

In response to our CY 2009 proposed rule, only a few commenters were concerned about the inclusion of inadequately trained practitioners and risks to patient safety under this expanded definition. Another commenter stated that this definition goes beyond the scope of the provisions in the MMA and the strict definition of ''physician'' in the statute. However, the majority of comments supported this proposal.

We did not receive any feedback during the CAP postponement that would lead for us to reconsider this proposal. Therefore, we again proposed to further clarify that, for the purposes of the CAP, the definition of a physician included all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act, as well as practitioners (such as NPs, CNSs and PAs) described in section 1861(s)(2)(K) of the Act and other practitioners who legally prescribe drugs associated with services under section 1861(s) of the Act if those services and the associated drugs are covered when furnished incident to a physician's services.

Our proposal was specific to the Part B Drug CAP and was not intended to affect the definition of physician in section 1861(r) of the Act, or the definition of ''Medical and Other Health Services'' described in section 1861(s) of the Act. The proposal also did not seek to expand the scope of the CAP beyond what has been described in previous rules, other than to clarify that a small number of providers who are enrolled in Medicare, and who legally prescribe drugs associated with services under section 1861(s) of the Act and can be paid by Medicare may elect to participate in the CAP if billing independently. In short, the CAP remains a program that provides Part B drugs furnished incident to a physician's services.

The following is summary of the comments we received regarding the updated definition of a CAP physician.

Comment: The majority of commenters supported our proposal to expand the definition of a physician for the purposes of the CAP. Commenters indicated that this proposal could increase patient access to drugs and treatment options, particularly in rural and underserved areas. It could also increase physician participation in the CAP and allow for greater program flexibility. However, some comments

expressed concerns about our approach. One commenter was concerned about the inclusion of inadequately trained health professionals and risks to patient safety under this expanded definition. This commenter also urged us to limit what types of CAP drugs could be handled by these additional health professionals included under our proposal. Another comment indicated that CMS more thoroughly refine its definition of ''physician'' through regulation since our proposed rule language seemingly implied that health practitioners included in this expanded definition who participate in the CAP could administer drugs regardless of any state-level prescription and administration laws. Another commenter indicated that we had exceeded our regulatory authority by expanding the definition of physician to include health professionals beyond those listed in section 1861(r) of the Act.

Response: We appreciate the comments that supported our proposal; however, we have further considered the comments on the 2009 PFS rule and the 2010 PFS proposed rule that cautioned us about potentially exceeding the statutory definition of a physician under section 1861(r) of the Act. Our proposal's intent was not to affect the definition of physician as specified in section 1861(r) of the Act. Upon further consideration in light of the comments, we agree that our proposal to expand the definition of a CAP physician is problematic, because it can be interpreted to be in conflict with section 1861(r) of the Act. Section 1847B of the Act specifically uses the term ''physician'' rather than a more general term, like provider, to describe who may select a CAP contractor to supply CAP drugs. Section 1861(r) of the Act specifies that the term physician includes, in some cases subject to certain limitations, the following types of practitioners: a doctor of medicine or osteopathy, a doctor of dental surgery or of dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor.

Therefore, at this time, we will not be revising the definition of a CAP physician beyond what was previously stated in the November 21, 2005 IFC (70 FR 70258), that is for the purposes of the CAP, a physician includes all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act. Based on CAP physician election data, we believe that the impact of not updating our definition at this time will have minimal impact on access to CAP drugs.

(2) Easing the Restriction on Physicians Transporting CAP Drugs

Although section 1847B(b)(4)(E) of the Act provides for the shipment of CAP drugs to settings other than a participating CAP physician's office under certain conditions, in initially implementing the CAP, we did not propose to implement the CAP in alternative settings. We implemented the CAP with a restriction that CAP drugs be shipped directly to the participating CAP physician, as stated in § 414.906(a)(4), and that participating CAP physicians may not transport CAP drugs from one location to another, as stated in § 414.908(a)(3)(xii). However, we were aware that physicians may desire to administer drugs in alternative settings. Therefore, in the July 6, 2005 IFC, we sought comment on how this could be accommodated under the CAP in a way that addresses the potential vendors' concerns about product integrity and damage to the approved CAP vendors' property (70 FR 39048). We discussed comments submitted in response to the July 6, 2005 IFC in the CY 2008 PFS proposed rule (72 FR 38158). We also requested comments in the CY 2008 PFS proposed rule (72 FR 38157) on the potential feasibility of easing the restriction on transporting CAP drugs where this is permitted by State law and other applicable laws and regulations. We responded to submitted comments in the CY 2008 PFS final rule with comment period (72 FR 66268).

In the CY 2009 PFS proposed rule (70 FR 38523), we proposed to permit the transportation of CAP drug between a participating CAP physician's practice locations subject to voluntary agreements between the approved CAP vendor and the participating CAP physician. Because of the 2009 CAP postponement, we did not address this issue in the CY 2009 PFS final rule. However, we did receive the following comments in response to our proposed rule on easing transportation restrictions in the CAP:

- Many commenters indicated that this change would increase program flexibility and facilitate patient treatment.
- Some commenters were supportive, but also raised concerns about drug integrity and liability, and requested that appropriate safeguards be in place before transportation restrictions were eased.
- Generally, commenters wanted CMS to explicitly delineate standards about voluntary agreements that address concerns about product integrity, liability, transportation procedures, and documentation. One commenter indicated that such standards should be developed through a separate rulemaking period to allow for public comment.
- Several commenters cited State pedigree laws as possible impediments to physician transport of drugs.

We also requested and received feedback about the program during the 2009 postponement period. One member of the potential vendor community urged us to be mindful of increased legal liability for an approved CAP vendor if this policy were to be implemented, but also acknowledged that the proposal might substantially increase physician interest in the program.

We continue to be mindful of the concerns expressed by the commenters, and have evaluated both the advantages and disadvantages of easing the restriction on transportation of CAP drugs. Thus, we again proposed to permit transport of CAP drug between a participating CAP physician's practice locations subject to voluntary agreements between the approved CAP vendor and the participating CAP physician. As indicated in our CY 2009 PFS proposed rule, we continued to propose that such agreements must comply with all applicable State and Federal laws and regulations and product liability requirements, and be documented in writing.

We would again like to reiterate the voluntary nature of these proposed agreements. Approved CAP vendors would not be required to offer and participating CAP physicians would not be required to accept such agreements when selecting an approved CAP vendor. An approved CAP vendor may not refuse to do business with a participating CAP physician because the participating CAP physician has declined to enter into such an agreement with the approved CAP vendor. Furthermore, we are not seeking to define which CAP drugs may be subject to the proposed voluntary agreements. In other words, each approved CAP vendor could specify which CAP drug(s) could be transported.

However, our proposal continues to contain certain limitations. In previous rulemaking, we have described requirements for voluntary agreements between approved CAP vendors and participating CAP physicians. In the July 6, 2005 IFC (70 FR 39050) and the CY 2006 PFS final rule (70 FR 70251 through 70252), we stated that we will not dictate the breadth of use or the specific obligations contained in voluntary arrangements between approved CAP vendors and

participating CAP physicians, other than to note that they must comply with applicable law and to prohibit approved CAP vendors from coercing participating CAP physicians into entering any of these arrangements. Parties to such arrangements must also ensure that the arrangements do not violate the physician self-referral (''Stark'') prohibition (section 1877 of the Act), the Federal anti-kickback statute (section 1128B(b) of the Act), or any other Federal or State law or regulation governing billing or claims submission. We proposed to apply these standards to any agreement for the transport of CAP drugs.

We remain concerned about opportunities for disruption in the drug's chain of custody and appropriate storage and handling conditions that may ultimately affect patient care or increase the risk of drug theft or diversion. Therefore, in order to maintain safety and drug integrity in the CAP and to protect against the fraudulent diversion of CAP drugs, we reproposed that any voluntary agreements between an approved CAP vendor and a participating CAP physician regarding the transportation of CAP drug must include requirements that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported. We solicited comments on these issues, including the identification of who may transport the drugs, how documentation of transportation activities could be accomplished, and how the oversight of such agreements will be carried out.

In conclusion, we believe that the proposal to ease the restriction on transporting CAP drugs between a participating CAP physician's practice locations—when agreed upon by the participating CAP physician and the approved CAP vendor—will make the CAP more flexible and ultimately more appealing to participating CAP physicians. Additionally, we believe that this proposal will facilitate the participation of CAP physicians who have office locations in rural areas and/or have satellite offices with limited hours. Moreover, we believe that this proposal will promote beneficiary care, particularly for beneficiaries who live in rural locations. Since participating CAP physicians would be able to transport CAP drugs to another office location in accordance with a voluntary agreement with their approved CAP vendor, beneficiaries would have more flexibility in scheduling the location of their appointments. We solicited comments about this proposal.

The following is summary of the comments we received regarding the proposal to ease transport restrictions between participating CAP physicians' offices.

Comment: The comments represented a variety of perspectives and were very similar to the comments discussed in our previous proposal and outlined in the bullet points above. Many comments were supportive, but some also raised reservations pertaining to drug integrity and liability. The commenters requested that appropriate safeguards be in place before transportation restrictions were eased and that liability should be clearly defined in these voluntary agreements. One commenter supported our proposal, but indicated that concerns about drug integrity and liability would prevent approved CAP vendors from offering such voluntary agreements for transporting CAP drug. Another commenter indicated that the approved CAP vendor must be responsible for notifying physicians of handling or storage requirements for any drug. Two commenters indicated that licensed practitioners are able to take responsibility for transporting drugs because of their training and knowledge. A commenter requested that we develop specific transportation standards through a separate rulemaking period. Another comment indicated that the approved CAP vendor should develop and submit explicit drug transportation standards to CMS. One commenter suggested that CMS require physicians to document drug transfers via a standardized transport sheet.

A number of comments were supportive of our proposal and indicated that this change would increase program flexibility, make the program more desirable to physicians, and facilitate patient treatment. One commenter understood our proposal to mean that we would ''ship'' CAP drug directly to the site of service. Another commenter suggested that approved CAP vendors should be required to offer such agreements. Several commenters cited State pedigree laws as possible impediments to physician transport of drugs.

Response: Overall, there was support for our proposal and we agree that these agreements would provide flexibility for CAP providers. We agree with commenters who expressed concerns about product integrity and liability. However, we do not agree that additional CMS involvement such as developing detailed and specific agreements now, or through other means such as separate rulemaking, will contribute to the quality or appropriateness of these agreements. We believe that the details of these agreements can best be determined by the parties that participate in the agreement rather than CMS. Detailed knowledge about applicable State laws (including ''pedigree laws''), practice requirements and specialized knowledge about drug handling are beyond CMS' expertise. However, we believe that our proposal outlines a sufficient framework of safeguards and provisions to mitigate risks associated with damage to the product, drug diversion, and financial loss. We have stated that agreements must be made in writing and must comply with all applicable State and Federal laws and regulations and product liability requirements and must include requirements that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported.

We are not seeking to define specific items in these agreements, such as which CAP drugs may be subject to the proposed voluntary agreements regarding drug transport because the parties involved in the agreement will have the greatest insight regarding such details and will better understand the variables and practical applications associated with these decisions. Drugs that may be furnished under the CAP are subject to a broad range of storage requirements—some drugs are especially temperature sensitive and some may be light sensitive.

Also, some CAP drugs are very expensive, and the loss of even a single dose could create significant financial impact for an approved CAP vendor. We believe that assessments and decisions about which drugs may be transported must be made by the approved CAP vendor at the drug level in order to allow the approved CAP vendor to better control the risk associated with transporting vendor-owned product and to apply its knowledge and expertise in product handling in order to either facilitate, or to choose not to allow the transportation of certain drugs that may require special handling, such as strict temperature control or limits to light exposure. So long as they are consistent with the standards we have set forth for these voluntary agreements, we also believe such agreements can address issues of financial liability for the drug, and we believe that the approved CAP vendor is in the best position to assess the financial risk associated with the transportation of specific drugs, and to make corresponding changes as new drugs are added to the CAP, or information about drugs already supplied under the CAP changes.

We are also concerned that additional CMS involvement regarding the details of these agreements could cause negative consequences by further delaying the implementation of this provision, or delays in responding to changes as new drugs become available under the CAP. Because the parties to the agreement have a better understanding of the specific information that must be used to assess each drug, CMS involvement could also result in the addition of requirements that may not be necessary, or the exclusion of requirements that may be beneficial. Providing a framework rather than specific requirements also provides an adaptable and scalable solution that can accommodate different drugs with different handling requirements, different participating CAP physician populations, and individual approved CAP vendors' financial risk assessments at the drug level.

We also note that shipment of drugs and biologicals often across significant distances is being done routinely by pharmacies, drug distributors, and home infusion providers. Therefore, we believe that significant practical experience associated with safely transporting drugs between various locations outside of standard shipping arrangements exists, and this experience could be applied to the transportation agreements. We encourage approved CAP vendors who enter into agreements with participating CAP physicians to permit transport of one or more CAP drugs between offices to assist with the dissemination of details and practical applications of specialized knowledge about drug handling and to either specify, or provide mechanisms to track, drugs that are being transported between offices.

We also agree with the comments that stated that participating CAP physicians and other CAP practitioners are able to follow the handling requirements associated with the drugs that they administer and we agree that they may be held responsible for adherence to those requirements. We believe that the participating CAP physicians will want to adhere to these requirements not only for the safety of the beneficiary who will receive the drug, but also for the financial well being of the approved CAP vendor—the entity that still owns the drug.

Based on the comments that we received, we are finalizing our proposal to ease the transportation restriction between a participating CAP physicians' offices as listed on the CAP physician election agreement using voluntary agreements between the approved CAP vendors and participating CAP physicians. The finalized proposal does not affect the current requirement that drugs be shipped from the approved CAP vendor only to a participating CAP physician.

We also remind readers that the change applies only to transportation of CAP drugs between the offices of a group to which the drug was shipped and does not include shipment to office locations not listed on the physician's election agreement, or transportation to sites other than the participating CAP physician's offices; these issues are outside the scope of what we had proposed.

We also remind readers that at a minimum, voluntary agreements that allow the transportation of CAP drugs between office locations must comply with all applicable State and Federal laws and regulations and product liability requirements, and be documented in writing and must include requirements that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported. While we are not dictating the breadth of use or the specific obligations contained in voluntary arrangements between approved CAP vendors and participating CAP physicians, including the drugs covered by an agreement, the agreements must comply with applicable law and prohibit approved CAP vendors from coercing participating CAP physicians into entering any of these arrangements. Parties to such arrangements must also ensure that the arrangements do not violate the physician self-referral (''Stark'') prohibition (section 1877 of the Act), the Federal anti-kickback statute (section 1128B(b) of the Act), or any other Federal or State law or regulation governing billing or claims submission.

By way of example only, we believe that a voluntary agreement between the participating CAP physician and approved CAP vendor could also be used to address the following issues: assignment of financial liability associated with product loss or damage, tracking and stock reconciliation mechanisms, oversight and compliance mechanisms, who may transport the drug, and specific handling requirements for the each of the drugs that may be transported.

(3) Dispute Resolution Process

In the CY 2009 PFS proposed rule (73 FR 38524 through 38525), we discussed two changes to the CAP dispute resolution process. Section 1847B(b)(2)(A)(ii)(II) of the Act requires an approved CAP vendor to have a grievance and appeals process for the resolution of disputes. In the July 6, 2005 IFC (70 FR 39054 through 39058), we described the process for the resolution of participating CAP physicians' drug quality and service complaints and approved CAP vendors' complaints regarding noncompliant participating CAP physicians. We encouraged participating CAP physicians, beneficiaries, and vendors to use informal communication as a first step to resolve service-related administration issues. However, we recognized that certain disputes would require a more structured approach, and therefore, we established processes under § 414.916 and § 414.917.

(i) Approved CAP Vendor's Status During the Reconsideration Process

Section 414.917 outlines the dispute resolution process for participating CAP physicians. As discussed in the July 6, 2005 IFC (70 FR 39057 through 39058), if a participating CAP physician finds an approved CAP vendor's service or the quality of a CAP drug supplied by the approved CAP vendor to be unsatisfactory, then the physician may address the issues first through the approved CAP vendor's grievance process, and second through an alternative dispute resolution process administered by the designated carrier and CMS. In turn, the designated carrier would gather information about the issue as outlined in § 414.917(b)(2) and make a recommendation to CMS on whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. We would then review and act on that recommendation after gathering any necessary, additional information from the participating CAP physician and approved CAP vendor. If we suspend an approved CAP vendor's CAP contract for noncompliance or terminate the CAP contract in accordance with § 414.914(a), the approved CAP vendor may request a reconsideration in accordance with § 414.917(c).

In the July 6, 2005 IFC (70 FR 39058), we indicated that the approved CAP vendor's participation in the CAP would be suspended while the approved CAP vendor's appeal of our decision is pending. This suspended status is also implied in § 414.917(c)(9), which states that the ''approved CAP vendor may resume participation in CAP'' if the final reconsideration determination is favorable to the approved CAP vendor. In order to improve the clarity of our regulations, we proposed in the CY 2009 PFS proposed rule that the approved CAP vendor's contract will remain suspended during the reconsideration

period in § 414.917 (73 FR 38525). We believed that this proposed technical change is consistent with basic contracting concepts and with our current practices for the CAP. This proposal was not finalized due to the 2009 CAP postponement.

Comments submitted in response to our CY 2009 PFS proposed rule supported this proposed clarification and we did not receive additional feedback about this issue after the CAP was postponed. Based on this and our continued need to improve the clarity of our regulations, we reproposed that the approved CAP vendor's contract will remain suspended during the reconsideration period in § 414.917. We solicited additional comments on our proposal.

Comment: One commenter supported our proposal regarding the CAP's dispute resolution process.

Response: We are finalizing our proposal that the approved CAP vendor's contract will remain suspended during the reconsideration period in § 414.917. We believe that this technical change is consistent with basic contracting concepts and with our current practices for the CAP.

(ii) Termination of CAP Drug Shipments to Suspended CAP Physicians

Section 414.916 provides a mechanism for approved CAP vendors to address noncompliance problems with participating CAP physicians. As stated at § 414.916(a), ''Cases of an approved CAP vendor's dissatisfaction with denied drug claims are resolved through a voluntary alternative dispute resolution process delivered by the designated carrier, and a reconsideration process provided by CMS.'' Once the decision is made to suspend a participating CAP physician's CAP election agreement, the participating CAP physician will be suspended from the CAP as described in § 414.916(b)(3).

Physicians whose participation in the CAP has been suspended are not eligible to receive CAP drugs. This is implied in § 414.906(a)(4), which speaks of approved CAP vendors providing CAP drugs directly to ''[a] participating CAP physician.'' However, we believe that the clarity of our dispute resolution regulations would be improved if this drug delivery issue were stated explicitly. Therefore, in the CY 2009 PFS proposed rule, we proposed to revise § 414.916 to specify that approved CAP vendors shall not deliver CAP drugs to participating CAP physicians whose participation in the CAP has been suspended after an initial determination by CMS. The proposal also applied to physicians engaged in the reconsideration process outlined in § 414.916(c) and included a conforming change at § 414.914(f)(12). We believed that these changes were in accord with the underlying intent of § 414.916, namely to provide a mechanism for approved CAP vendors to address noncompliance problems with participating CAP physicians, and we believe that these changes will increase the clarity of our regulations. We also noted that the participating CAP physicians who are suspended from participation in the CAP will be able to obtain drugs and bill for them under the ASP payment system provided they have not been excluded from participation in Medicare and/or their billing privileges have not been revoked.

Comments submitted in response to the CY 2009 PFS proposed rule agreed with our proposal. Though we did not finalize this proposal due to the 2009 CAP postponement, we received no comments from the public in response to our request for feedback during the CAP 2009 postponement. Based on positive public feedback and our continued belief that the clarity of our dispute resolution regulations would be improved by being explicit about this issue, we reproposed to revise § 414.916 to specify that approved CAP vendors shall not deliver CAP drugs to participating CAP physicians whose participation in the CAP has been suspended after an initial determination by CMS. This suspension in drug shipment would also apply to physicians engaged in the reconsideration process outlined in § 414.916(c). We have also proposed a conforming change to § 414.914(f)(12). Physicians who are suspended from participation in the CAP will be able to obtain drugs and bill for them under the ASP payment system provided they have not been excluded from participation in Medicare and/or their billing privileges have not been revoked.

Comment: We received comments that both supported and opposed this proposal. One commenter supported this approach. Another commenter questioned the sufficiency of our procedures and indicated that the suspension of CAP drug shipments to a physician should not be implemented after an initial determination by CMS, but rather only after a final decision on reconsideration has been made.

Response: We disagree with the comment about the sufficiency of our dispute resolution procedures. We believe that in light of the very limited grounds for which a participating CAP physician may be suspended, the protections afforded under § 414.916(b)(3) prior to CMS's initial decision to suspend the physician from the CAP are sufficient. Indeed, a participating CAP physician may be suspended from the CAP only upon CMS approval after: information is collected and analyzed by the carrier on the issue of whether the participating CAP physician has been filing his or her CAP drug administration claims in accordance with the requirements of § 414.908(a)(3), the designated carrier provides numbered findings of fact to CMS, and CMS reviews the carrier's information and gathers relevant additional information from the participating CAP physician. These procedures allow a participating CAP physician to be actively involved in the dispute resolution process prior to CMS's decision to suspend the CAP election agreement. For these reasons, we believe that appropriate initial mechanisms are in place to protect the physician's access to drugs under the CAP.

Furthermore, physicians who are suspended from participation in the CAP and to whom the approved CAP vendor has ceased shipments of CAP drugs are able to obtain drugs and bill for them under the ASP payment system. Thus, these physicians will have continuous access to Part B drugs. Finally, because a participating CAP physician's failure to comply with regulations at § 414.908(a)(2) can negatively affect the approved CAP vendor's ability to receive payment for CAP drugs that it shipped to the physician, we believe that suspending shipment of CAP drugs upon CMS's initial determination of suspension of the CAP physician election agreement appropriately balances the needs of the participating CAP physician and those of the approved CAP vendor. For the foregoing reasons, at this time, we are finalizing our proposal that approved CAP vendors shall not ship CAP drugs to physicians whose participation in the CAP has been suspended after an initial determination by CMS.

I. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities

In the CY 2010 PFS proposed rule (74 FR 33634 through 33639), we outlined the proposed updates to the case-mix adjusted composite rate payment system established under section 1881(b)(12) of the Act, as added by section 623 of the Medicare Modernization Act (MMA), which included updates to the drug add-on component of the composite rate system, as well as the wage index values used to adjust the labor component of

the composite rate. Specifically, as described in more detail below in this section, we proposed the following:

- A zero growth update to the proposed 15.0 add-on adjustment to the composite rates for 2010 required by section 1881(b)(12)(F) of the Act (resulting in a $20.33 per treatment drug add-on amount).
- An update to the wage index adjustment to reflect the latest available wage data, including a revised BN adjustment factor of 1.057888.
- A reduction to the ESRD wage index floor from 0.7000 to 0.6500.

We received few public comments on our proposals. The ESRD payment related comments are discussed in detail below in this section. In addition, as discussed in section II.G.12. of this rule, section 1881(b)(12)(G)(iv) of the Act, as added by section 153(a)(1) of the MIPPA, increases the composite rate by 1.0 percent for ESRD services furnished on or after January 1, 2010. Therefore, the 1.0 percent increases the current composite rate of $133.81 to $135.15 for services furnished on or after January 1, 2010.

1. Update to the Drug Add-on Adjustment to the Composite Rate

Section 1881(b)(12)(B)(ii) of the Act, as added by section 623(d) of the MMA, requires an add-on to the composite rate to account for changes in the drug payment methodology. Section 1881(b)(12)(C) of the Act provides that the drug add-on must reflect the difference in aggregate payments between the revised drug payment methodology for separately billable ESRD drugs and the Average Wholesale Price (AWP) payment methodology. In 2005, we generally paid for ESRD drugs based on average acquisition costs. Thus the difference from AWP pricing was calculated using acquisition costs. However, in 2006 when we moved to Average Sales Price (ASP) pricing for ESRD drugs, we recalculated the difference from AWP pricing using ASP prices.

In addition, section 1881(b)(12)(F) of the Act requires that, beginning in CY 2006, we establish an annual increase to the drug add-on to reflect estimated growth in expenditures for separately billable drugs and biologicals furnished by ESRD facilities. This growth update applies only to the drug add-on portion of the case-mix adjusted payment system. The CY 2009 drug add-on adjustment to the composite rate was 15.2 percent. The drug add-on adjustment for CY 2009 reflected a zero increase. This computation is explained in detail below and in the CY 2009 PFS final rule with comment period (73 FR 69755 through 69757).

a. Estimating Growth in Expenditures for Drugs and Biologicals for CY 2010

Section 1881(b)(12)(F) of the Act specifies that the drug add-on increase must reflect ''the estimated growth in expenditures for drugs and biologicals (including erythropoietin) that are separately billable * * *'' By referring to ''expenditures'', we believe the statute contemplates that the update would account for both increases in drug prices, as well as increases in utilization of those drugs.

In the CY 2007 PFS final rule with comment period (71 FR 69682), we established an interim methodology for annually estimating the growth in ESRD drugs and biological expenditures that used the Producer Price Index (PPI) for pharmaceuticals as a proxy for pricing growth in conjunction with 2 years of ESRD drug data to estimate per patient utilization growth. We indicated that this interim methodology would be used to update the drug add-on to the composite rate until such time that we had sufficient ASP drug expenditure data to project the growth in ESRD drug expenditures.

However, for CY 2008, due to declining ASP prices, we no longer believed that using the PPI as a proxy for pricing growth was appropriate. Accordingly, for CY 2009, we revised the interim methodology for estimating the growth in ESRD drug expenditures by using ASP pricing to estimate the price component of the update calculation. Due to the declining trend in ASP pricing and utilization, we calculated a decrease in the drug add-on adjustment, and applied a zero update to the drug add-on adjustment (73 FR 69755 through 69757).

b. Estimating Growth in Expenditures for Drugs and Biologicals in CY 2010

Since we now have 3 years of drug expenditure data based on ASP pricing, we have reevaluated our methodology for estimating growth in drug expenditures. We believe that 3 years of drug expenditure data based on ASP pricing is sufficient to project drug expenditure growth based on trend analysis. Therefore, for CY 2010, we proposed to use trend analysis from ASP drug expenditure data to update the per treatment drug add-on adjustment (74 FR 33636).

In addition, we proposed to estimate per patient growth in drug expenditures by removing growth in ESRD enrollment from growth in total drug expenditures. To estimate drug expenditure growth using trend analysis, we looked at the average annual growth in total drug expenditures between 2006 and 2008. First we had to estimate the total drug expenditures for all ESRD facilities in CY 2008. For the CY 2010 PFS proposed rule, we used the final CY 2006, the final CY 2007 ESRD claims data, and the latest available CY 2008 ESRD facility claims, updated through December 31, 2008 (that is, claims with dates of service from January 1 through December 31, 2008, that were received, processed, paid, and passed to the National Claims History File as of December 31, 2008). For the CY 2010 PFS proposed rule, we adjusted the December 2008 file to reflect our estimate of what total drug expenditures would be using the final June 30, 2009 bill file for CY 2008 (74 FR 33636). The net adjustment we applied to the CY 2008 claims data was an increase of 11.1 percent to the December 2008 claims file. In this final rule with comment period, we are using additional updated CY 2008 claims with dates of service for the same timeframe. This updated CY 2008 data file will include claims received, processed, paid, and passed to the National Claims History File as of June 30, 2009.

Using the full-year 2008 drug expenditure figure, we calculated the average annual change in drug expenditures from 2006 through 2008. This average annual change showed a decrease of 1.7 percent for this timeframe. We are using this 1.7 percent decrease to project drug expenditures for both 2009 and 2010.

c. Estimating per Patient Growth

Once we determined the projected growth in drug expenditures from 2009 to 2010, we then removed growth in enrollment for the same time period from the expenditure growth, so that the residual reflects per patient expenditure growth (which includes price and utilization combined). We believe that this approach is consistent with section 1881(b)(12)(F) of the Act, which requires us to annually update the drug add-on adjustment. To calculate the per patient growth in drug expenditures between CYs 2009 and 2010, we removed the enrollment component which represents the estimated growth in enrollment between CY 2009 and CY 2010. This was approximately 1.9 percent. To determine the growth in per patient expenditures, we divided the total drug expenditure decrease between 2009 and 2010 of 1.7 percent ($1.000 - 0.017 = 0.983$) by enrollment growth of 1.9 percent (1.019) for the same timeframe. The result is a per patient expenditure growth factor equal to 0.965 ($0.983/1.019 = 0.965$). Thus, we

are projecting a 3.5 percent decrease in per patient growth in drug expenditures between 2009 and 2010 (0.965 = 1.000–0.035).

d. Applying the Growth Update to the Drug Add-On Adjustment

In the CY 2006 PFS final rule (71 FR 69683), we applied the projected growth update percentage to the total amount of drug add-on dollars established for CY 2005 to establish a dollar amount for the CY 2006 growth update. In addition, we projected the growth in dialysis treatments for CY 2006 based on the projected growth in ESRD enrollment. We divided the projected total dollar amount of the CY 2006 growth by the projected growth in total dialysis treatments to develop the per treatment growth update amount. This growth update amount, combined with the CY 2005 per treatment drug add-on amount, resulted in an average drug add-on amount per treatment of $18.88 (or a 14.5 percent adjustment to the composite rate) for CY 2006.

In the CY 2007 PFS final rule with comment period (71 FR 69684), we revised our update methodology by applying the growth update to the per treatment drug add-on amount. That is, for CY 2007, we applied the growth update factor of 4.03 percent to the $18.88 per treatment drug add-on amount for an updated amount of $19.64 per treatment.

In the CY 2008 PFS final rule with comment period (72 FR 66282), we revised our update methodology by applying the growth update to the per treatment drug add-on amount. That is, for CY 2008, we applied the growth update factor of 3.5 percent to the $19.64 per treatment drug add-on amount for an updated amount of $20.33 per treatment.

In the CY 2009 PFS final rule with comment period (73 FR 69755 through 69757), we applied a zero update to the per treatment drug add-on amount which left it at $20.33. As discussed in detail below, for CY 2010, we again will apply a zero update to the per treatment drug add-on amount of $20.33 established in CY 2008.

e. Update to the Drug Add-on Adjustment

As discussed previously in this section, we estimate a 1.7 percent decrease in total drug expenditures between CY 2009 and CY 2010. Growth in per patient drug expenditures is computed by dividing growth in total drug expenditures by growth in enrollment for the same time period. Therefore, to calculate growth in per patient drug expenditures, we remove the enrollment component, which is an estimated increase of 1.9 percent (1.019) from growth in total drug expenditures, which is an estimated decrease of 1.7 percent (1.000 − 1.017 = 0.983). As described above, the removal of the enrollment component from total drug expenditures is computed as follows: 0.983/1.019 = 0.965. Therefore, we are projecting a 3.5 percent decrease in per patient growth of drug expenditures between CY 2009 and CY 2010. However, similar to last year and as indicated above, we are finalizing a zero update to the drug add-on adjustment.

We believe this approach is consistent with the language under section 1881(b)(12)(F) of the Act which states in part that ''the Secretary shall annually increase'' the basic case-mix adjusted payment amounts by an amount determined by applying the estimated growth in expenditures for separately billed ESRD drugs for the drug add-on amount. Our understanding of the statute contemplates ''annually increase'' to mean a positive or zero update to the drug add-on. Therefore, we will apply a zero update to maintain the $20.33 per treatment drug add-on amount for CY 2010. The current $20.33 per treatment drug add-on reflected a 15.2 percent drug add-on adjustment to the composite rate in effect for CY 2009. However, given that the MIPPA mandates a 1 percent increase to the composite rate (effective January 1, 2010), this 1 percent increase results in a decrease in the CY 2009 drug add-on adjustment from 15.2 percent to 15.0 percent to keep the drug add-on amount at $20.33 per treatment.

Comment: Many commenters agreed with our decision to continue to use the ASP+6 percent methodology for separately billable drugs. The commenters indicated that the ASP+6 percent methodology is appropriate since the drugs will be reimbursed at the same amount as they would when furnished in a physician office.

Response: Although we did not propose any changes to reimbursement for separately billiable ESRD drugs and biologicals, we appreciate the commenters' support of our use of the ASP+6 percent methodology.

Comment: The commenters also agreed with our decision to continue with a zero update to the drug add-on adjustment. MedPAC stated that although it recognizes the elimination of the drug add-on payment will occur beginning January 1, 2011, MedPAC believes that the composite payment rate and the drug add-on should be combined because the add-on payment is complex and may not be the most appropriate way to pay for dialysis services

Response: We appreciate the commenter's support that we continue with a zero update to the drug add-on adjustment. As we explained above, we are finalizing our proposal to provide a zero update to the drug add-on adjustment for CY 2010. With regard to MedPAC's suggestions, under the proposed bundled ESRD prospective payment system (PPS) effective in CY 2011, the drug add-on adjustment will be eliminated for ESRD providers and facilities that opt to be paid under the proposed ESRD PPS system beginning in CY 2011 (and not go through the 4-year transition). However, we note that under the proposed ESRD PPS, we will continue to update the drug add-on adjustment during the transition period. For further details regarding the proposed ESRD PPS, please refer to the Medicare End-State Renal Disease Prospective Payment System Proposed Rule (74 FR 50003 to 50005).

f. Update to the Geographic Adjustments to the Composite Rate

Section 1881(b)(12)(D) of the Act, as amended by section 623(d) of the MMA, gives the Secretary the authority to revise the wage indexes previously applied to the ESRD composite rate. The purpose of the wage index is to adjust the composite rates for differing wage levels covering the areas in which ESRD facilities are located. The wage indexes are calculated for each urban and rural area. In the CY 2006 PFS final rule with comment period (70 FR 70167), we announced our adoption of the OMB CBSA-based geographic area designations to develop revised urban/rural definitions and corresponding wage index values for purposes of calculating ESRD composite rates. In addition, we generally have followed wage index policies related to these definitions used under the inpatient hospital prospective payment system (IPPS), but without regard to any approved geographic reclassification authorized under sections 1886(d)(8) and (d)(10) of the Act or other provisions that only apply to hospitals paid under the IPPS (70 FR 70167). For purposes of the ESRD wage index methodology, the hospital wage data we use is pre-classified, pre-floor hospital data and unadjusted for occupational mix.

g. Updates to Core-Based Statistical Area (CBSA) Definitions

In the CY 2006 PFS final rule with comment period (70 FR 70167), we announced our adoption of the OMB's CBSA-based geographic area

designations to develop revised urban/rural definitions and corresponding wage index values for purposes of calculating ESRD composite rates. The CBSA-based geographic area designations are described in OMB Bulletin 03–04, originally issued June 6, 2003, and is available online at *http://www.whitehouse.gov/omb/bulletins/b03-04.html.* In addition, OMB has published subsequent bulletins regarding CBSA changes, including changes in CBSA numbers and titles. We wish to point out that this and all subsequent ESRD rules and notices are considered to incorporate the CBSA changes published in the most recent OMB bulletin that applies to the hospital wage index used to determine the current ESRD wage index. The OMB bulletins may be accessed online at *http://www.whitehouse.gov/omb/bulletins/index.html.*

h. Updated Wage Index Values

In the CY 2007 PFS final rule with comment period (71 FR 69685), we stated that we intended to update the ESRD wage index values annually. The ESRD final wage index values for CY 2010 were developed from FY 2006 wage and employment data obtained from the Medicare hospital cost reports. As we indicated above, the ESRD wage index values are calculated without regard to geographic classifications authorized under sections 1886(d)(8) and (d)(10) of the Act and utilize pre-floor hospital data that is unadjusted for occupational mix. We proposed to use the same methodology for CY 2010, using FY 2006 hospital data to develop the CY 2010 ESRD wage index values. For a detailed description of the development of the CY 2010 wage index values based on FY 2006 hospital data, see the FY 2010 IPPS final rule with comment period (74 FR 43834). Section III.G. of the preamble to the FY 2010 IPPS final rule with comment period, ''Method for Computing the Proposed FY 2010 Unadjusted Wage Index'', describes the cost report schedules, line items, data elements, adjustments, and wage index computations. The wage index data affecting the ESRD composite rate for each urban and rural locale may also be accessed on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp.* The wage data are located in the section entitled, ''FY 2010 Final Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-reclassified Wage Index by CBSA.''

In the CY 2009 final rule with comment period (73 FR 69758 and 69759), we indicated that CY 2009 was the final year of the transition period and each ESRD facility's composite payment rate would be based entirely on its applicable CBSA-based wage index value.

i. Reduction to the ESRD Wage Index Floor

In the CY 2009 PFS final rule with comment period, we stated our intention to continue to reassess the need for a wage index floor (73 FR 63758). We also stated that a gradual reduction in the floor is needed to support continuing patient access to dialysis in areas that have low wage index values, especially in Puerto Rico where the wage index values are below the current wage index floor. For CY 2010, we proposed to reduce the wage index floor from 0.70 to 0.65. We also anticipate that we may reduce the floor gradually until full implementation of the ESRD PPS required by section 1881(b)(14) of the Act.

Comment: We received comments from commenters in both Puerto Rico and Wheeling, WV–OH CBSA expressing concern about the reduction to the wage index floor.

Response: The majority of facilities located in Puerto Rico have wage indices significantly below the 0.65 floor. The steady reduction in the proposed ESRD wage index floor of 0.65 still remains higher than the actual wage index values which range from 0.3348 to 0.4740 for facilities located in Puerto Rico. Although a reduction in the wage index floor may negatively impact these providers, these facilities still benefit from a 0.65 floor rather than their actual wage index value.

There are 2 facilities located in Wheeling, WV–OH CBSA, which have an actual wage index value of 0.6869 and is above the proposed 0.65 floor, but not significantly below the CY 2009 0.70 floor. We note that the CY 2010 wage index value of 0.6869 for the Wheeling, WV–OH CBSA is prior to application of the wage index BN factor. After application of the wage index BN factor of 1.057735, the wage index value for Wheeling, WV–OH CBSA is 0.7266.

Comment: One commenter noted that the ESRD facilities in the Wheeling WV–OH CBSA have a wage index value that is less than the wage index value for rural WV. The commenter requested that CMS apply the rural floor policy that is applicable under the Hospital IPPS.

Response: Under the ESRD basic case-mix adjusted composite payment system, currently there is no mechanism for allowing providers to seek geographic reclassification. We reviewed the MedPAC's wage index recommendations as discussed in MedPAC's June 2007 report entitled ''Report to Congress: Promoting Greater Efficiency in Medicare.'' We note that MedPAC's June 2007 Report to Congress recommends that the Congress ''repeal the existing hospital wage index statute, including reclassification and exceptions, and give the Secretary authority to establish new wage index systems.'' We believe that adopting the IPPS wage index policies (such as the rural floor) for the ESRD wage index would not be prudent at this time, because MedPAC suggests that the reclassification and exception policies in the IPPS wage index alters the wage index values for one-third of IPPS hospitals. In addition, MedPAC found that the exceptions may lead to anomalies in the wage index. By adopting the IPPS rural floor at this time, the ESRD basic case-mix adjusted composite payment system wage index could become vulnerable to problems similar to those that MedPAC identified in their June 2007 Report to Congress. We will continue to review and consider MedPAC's recommendations on a refined or alternative wage index methodology for the IPPS and how it could potentially apply to the ESRD basic case-mix adjusted composite rate system in future years.

We also note that section 106(b)(2) of the Medicare Improvements and Extension Act (MIEA) of 2006 (which is Division B of the Tax Relief and Health Care Act (TRCHA) of 2006, Pub. L. 109–432, collectively referred to as ''MIEA–TRHCA'') required the Secretary of Health and Human Services, taking into account MedPAC's recommendations on the Medicare wage index classification system, to include in the FY 2009 IPPS proposed rule one or more proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the IPPS. To assist CMS in meeting the requirements of section 106(b)(2) of MIEA–TRHCA, in February 2008, we awarded a Task Order under its Expedited Research and Demonstration Contract, to Acumen, LLC. Acumen, LLC conducted a study of both the current methodology used to construct the Medicare wage index and the recommendations reported to the Congress by MedPAC. Part One of Acumen's final report, which analyzes the strengths and weaknesses of the data sources used to construct the CMS and MedPAC indexes, is available online at *http://www.acumenllc.com/reports/cms.* MedPAC's recommendations are presented in the FY 2009 IPPS final rule (73 FR 48745). We plan to continue monitoring IPPS wage index research efforts and the impact or influence these

efforts may have for the ESRD basic case-mix adjusted composite payment rate system wage index.

Moreover, in light of all of the pending research and review of wage index issues in general, we believe that it would be premature at this time to adopt the IPPS rural floor policy to the ESRD wage index.

j. Wage Index Values for Areas With No Hospital Data

In CY 2006, while adopting the CBSA designations, we identified a small number of ESRD facilities in both urban and rural geographic areas where there are no hospital wage data from which to calculate ESRD wage index values. The affected areas were rural Puerto Rico, and the urban area of Hinesville, GA (CBSA 25980), and rural Massachusetts. For CY 2006, CY 2007, CY 2008, and CY 2009, we calculated the ESRD wage index values for those areas as follows:

- For the urban area of Hinesville, GA, we calculated the CY 2006 through CY 2009 wage index value based on the average wage index value for all urban areas within the State of Georgia.
- For rural Massachusetts, because we had not determined a reasonable wage proxy, we used the FY 2005 wage index value in CY 2006 and CY 2007. As discussed below, we adopted an alternative methodology for CYs 2008 and 2009.
- For rural Puerto Rico, because all geographic areas in Puerto Rico were subject to the wage index floor in CYs 2006 through 2009, we applied the ESRD wage index floor to rural Puerto Rico as well. We note that there are currently no ESRD facilities located in rural Puerto Rico.

For CY 2008, we adopted an alternative methodology for establishing a wage index value for rural Massachusetts and continued to apply this methodology in CY 2009. Because we used the same wage index value for 2 years with no update, we believed it was appropriate to establish a methodology which employed reasonable proxy data for rural areas (including rural Massachusetts) and also permitted annual updates to the wage index based on that proxy data. For rural areas without hospital wage data, we used the average wage index values from all contiguous CBSAs as a reasonable proxy for that rural area.

In determining the imputed rural wage index, we interpreted the term ''contiguous'' to mean sharing a border. In the case of Massachusetts, the entire rural area consists of Dukes and Nantucket Counties. We determined that the borders of Dukes and Nantucket counties are contiguous with CBSA 12700, Barnstable Town, MA, and CBSA 39300, Providence-New Bedford-Fall River, RI–MA. We proposed to use the same methodology for CY 2010. Under this methodology, the CY 2010 final wage index values for CBSA 12700 (Barnstable Town, MA—1.2618) and CBSA 39300 (Providence-New Bedford-Fall River, RI–MA—1.0782) averages results in an imputed wage index value of 1.1700 for rural Massachusetts in CY 2010.

For rural Puerto Rico, for CY 2010, all areas in Puerto Rico that have a wage index are eligible for the proposed ESRD wage index floor of 0.65. Therefore, we proposed to apply the proposed ESRD wage index floor of 0.65 to facilities that are located in rural Puerto Rico.

For Hinesville-Fort Stewart, GA (CBSA 25980), which is an urban area without specific hospital wage data, we proposed to apply the same methodology used to impute a wage index value that we used in CY 2009. Specifically, we proposed to utilize the average wage index value for all urban areas within the State of Georgia. That would result in a CY 2010 final wage index value of 0.9028 for the Hinesville-Fort Stewart GA CBSA.

We received no comments on our proposals for wage areas with no hospital data. Therefore, we are finalizing our policies for wage areas with no hospital data as proposed.

In the CY 2009 PFS final rule with comment period (73 FR 69759 through 69760), we stated that we would continue to evaluate existing hospital wage data and possibly wage data from other sources such as the Bureau of Labor Statistics, to determine if other methodologies might be appropriate for imputing wage index values for areas without hospital wage data for CY 2010 and subsequent years. To date, no data from other sources, superior to that currently used in connection with the IPPS wage index has emerged. Therefore, for ESRD purposes, we continue to believe this is an appropriate policy.

k. Budget Neutrality Adjustment

Section 1881(b)(12)(E)(i) of the Act, as added by section 623(d) of the MMA, required that any revisions to the ESRD composite rate payment system as a result of the MMA provision (including the geographic adjustment) be made in a budget neutral manner. Given our application of the ESRD wage index, this means that aggregate payments to ESRD facilities in CY 2010 would be the same as aggregate payments that would have been made if we had not made any changes to the geographic adjusters. We note that this BN adjustment only addresses the impact of changes in the geographic adjustments. A separate BN adjustment was developed for the case-mix adjustments required by the MMA. As we did not propose any changes to the case-mix measures for CY 2010, the current case-mix BN adjustment of 0.9116 would remain in effect for CY 2010. As in CY 2009, for CY 2010, we proposed to apply the proposed wage-index BN adjustment factor of 1.057888 directly to the ESRD wage index values. Because the ESRD wage index is only applied to the labor-related portion of the composite rate, we computed the BN adjustment factor based on that proportion (53.711 percent).

To compute the proposed CY 2010 wage index BN adjustment factor (1.057888), we used the FY 2006 pre-floor, pre-reclassified, non-occupational mix-adjusted hospital data to compute the wage index values, 2008 outpatient claims (paid and processed as of December 31, 2008), and geographic location information for each facility which may be found through Dialysis Facility Compare Web page on the CMS Web site at *http://www.cms.hhs.gov/DialysisFacilityCompare/*. The FY 2006 hospital wage index data for each urban and rural locale by CBSA may also be accessed on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp*. The wage index data are located in the section entitled, ''FY 2010 Final Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-Reclassified Wage Index by CBSA.''

Using treatment counts from the 2008 claims and facility-specific CY 2009 composite rates, we computed the estimated total dollar amount each ESRD provider would have received in CY 2009. The total of these payments became the target amount of expenditures for all ESRD facilities for CY 2010. Next, we computed the estimated dollar amount that would have been paid for the same ESRD facilities using the ESRD wage index for CY 2010. The total of these payments became the new CY 2010 amount of wage-adjusted composite rate expenditures for all ESRD facilities. Section 153(a) of the MIPPA revised section 1881(b)(12)(G) of the Act to provide for an update of 1 percent to the composite rate component of the payment system effective January 1, 2010. We note that when computing the new CY 2010 amount, we did not include this 1 percent increase because the BN adjustment would negate the increase.

After comparing these two dollar amounts (target amount divided by the new CY 2010 amount), we calculated an

adjustment factor that, when multiplied by the applicable CY 2010 ESRD wage index value, would result in aggregate payments to ESRD facilities that would remain within the target amount of composite rate expenditures. When making this calculation, the final ESRD wage index floor value of 0.6500 is applied whenever appropriate. The final wage BN adjustment factor is 1.057735 for CY 2010.

To ensure BN, we also must apply the wage index BN adjustment factor to the wage index floor of 0.6500 which results in an adjusted wage index floor of 0.6875 (0.6500 x 1.057735) for CY 2010.

General Comments

Comment: One commenter supports our proposal to maintain the existing case-mix adjusters and believes it will be important to maintain consistency in the current composite rate by preserving the current case-mix adjustors, given the anticipated shift to a bundled payment system.

Response: As explained earlier in this section, we did not propose any changes to the current basic case-mix composite rate payment system. We have maintained the current basic case-mix adjusters for CY 2010. We have proposed a number of patient-level adjusters in the new bundled ESRD PPS system, which are explained in detail in the ESRD PPS proposed rule (74 FR 49925 and 49926).

l. ESRD Wage Index Tables

The CY 2010 ESRD wage index tables are located in Addenda F and G of this final rule with comment period.

J. Discussion of Chiropractic Services Demonstration

1. Background

Section 651 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) requires the Secretary to conduct a 2-year demonstration to evaluate the feasibility and advisability of expanding coverage for chiropractic services under Medicare. Medicare coverage for chiropractic services is limited to manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Act. The demonstration expanded current Medicare coverage to include ''care for neuromusculoskeletal conditions typical among eligible beneficiaries and diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided'' and was conducted in four geographically diverse sites, two rural and two urban regions, with each type including a Health Professional Shortage Area (HPSA). The two urban sites were 26 counties in Illinois and Scott County, Iowa, and 17 counties in Virginia. The two rural sites were the States of Maine and New Mexico. The demonstration, which ended on March 31, 2007, was required to be budget neutral as section 651(f)(1)(B) of the MMA mandates the Secretary to ensure that ''the aggregate payments made by the Secretary under the Medicare program do not exceed the amount which the Secretary would have paid under the Medicare program if the demonstration projects under this section were not implemented.''

In the CY 2006, 2007, and 2008 PFS final rules with comment period (70 FR 70266, 71 FR 69707, 72 FR 66325, respectively), we included a discussion of the strategy that would be used to assess BN and the method for adjusting chiropractor fees in the event the demonstration results in costs higher than those that would occur in the absence of the demonstration. We stated BN would be assessed by determining the change in costs based on a pre-post comparison of Medicare costs for beneficiaries in the demonstration and their counterparts in the control groups and the rate of change for specific diagnoses that are treated by chiropractors and physicians in the demonstration sites and control sites. We also stated that our analysis would not be limited to only review of chiropractor claims because the costs of the expanded chiropractor services may have an impact on other Medicare costs. If the demonstration was not budget neutral, we anticipated making reductions in the CY 2010 and CY 2011 physician fee schedules. We indicated that if we determined that the adjustment for BN was greater than 2 percent of spending for the chiropractor fee schedule codes, we would implement the adjustment over a 2-year period. However, if the adjustment was less than 2 percent of spending under the chiropractor fee schedule codes, we would implement the adjustment over a 1-year period.

2. Analysis of Demonstration

Brandeis University, the demonstration evaluator, used two approaches in examining BN. The ''All Neuromusculoskeletal Analysis (NMS)'' reflects an intent-to-treat approach whereby the utilization of all beneficiaries who received any Medicare covered services for neuromusculoskeletal conditions in the demonstration areas was examined. This method is potentially subject to large external forces because of its inclusion of all beneficiaries including those who did not use chiropractic services and who would not become users of chiropractic services, even with expanded coverage for them. Therefore, a second analysis, termed the ''Chiropractic User Analysis'' was conducted to examine only the subset of beneficiaries who used chiropractic services for the treatment of their neuromusculoskeletal conditions. Both approaches use hierarchical linear modeling of costs over 3 years—1 year prior to the demonstration and the 2 years of the demonstration. We posted a report describing these analyses on CMS Web site at *http://www.cms.hhs.gov/reports/downloads/MMA651_BudgetNeutrality.pdf.*

The results of both analyses indicate that the demonstration was not budget neutral. In the ''All NMS Analysis,'' which compared the Medicare costs associated with NMS conditions for *all* beneficiaries in the demonstration areas with those of beneficiaries with similar characteristics from similar geographic areas that did not participate in the demonstration, the total effect of the demonstration to Medicare was $114 million. In the ''Chiropractic User Analysis,'' which compared the Medicare costs associated with NMS conditions for beneficiaries who used expanded chiropractic services in the demonstration areas, with those of beneficiaries with similar characteristics who used chiropractic services as currently covered by Medicare to treat a neuromusculoskeletal condition from similar geographic areas that did not participate in the demonstration, the total effect of the demonstration to Medicare was $50 million.

Both approaches to assessing BN have strengths and limitations. The ''All NMS Analysis'' provides the broadest view of the Medicare population that would have been eligible for the demonstration's expanded coverage of chiropractic services. Its inclusion of all beneficiaries with neuromusculoskeletal conditions guards against validity threats of selection. However, this approach creates a large heterogeneous group which may only include a small proportion of chiropractic service users. Basing estimates of BN on such a large heterogeneous group increases the potential for changes in the use of services seldom affected by chiropractors to be falsely attributed to the demonstration, which could result in the costs of the demonstration to appear larger than actual.

Consistent with the CY 2010 PFS proposed rule (74 FR 33520, 33639 through 33640), for this final rule with comment period, we continue to believe

that the BN estimate should be based on the ''Chiropractic User Analysis'' because of its focus on users of chiropractic services rather than all Medicare beneficiaries with neuromusculoskeletal conditions, including those who did not use chiropractic services and who would not have become users of chiropractic services even with expanded coverage for them. Users of chiropractic services are most likely to have been affected by the expanded coverage provided by this demonstration. Cost increases and offsets, such as reductions in hospitalizations or other types of ambulatory care, are more likely to be observed in this group. Therefore, as proposed, we are adjusting the Medicare PFS for all chiropractors using the estimate provided in the ''Chiropractic User Analysis.''

The CMS Office of the Actuary (OACT) estimates chiropractic expenditures in CY 2010 to be approximately $487 million based on actual Medicare spending for chiropractic services for the most recent available year. Because the costs of this demonstration were higher than expected and we did not anticipate a reduction to the PFS of greater than 2 percent per year, we are finalizing our proposal (74 FR 33639 through 33640) to recoup the $50 million in expenditures from this demonstration over a 5-year period rather than over a 2-year period. As proposed, we are recouping $10 million each year through adjustments to the PFS for chiropractic codes in calendar years 2010 through 2014. This approach reflects a change from our BN discussion in the CY 2006, 2007, and 2008 PFS rules, which was described previously in this section. In those rules, we had proposed that if the adjustment for BN was greater than 2 percent of spending for the chiropractor fee schedule codes, the adjustment would be implemented over a 2-year period. Under this final rule, we are recouping costs by reducing payment under the PFS for chiropractic fee codes by $10 million each year starting CY 2010 through CY 2014. We note that in the proposed rule, we proposed a 2 percent reduction in the chiropractic fee codes in order to achieve the $10 million yearly recoupment. We note that 2 percent was an approximation. Because of rounding, the $10 million recoupment in each of CYs 2010 through 2014 will amount to approximately a 2 percent reduction since the reduction in the chiropractic fee codes may be slightly higher or lower than 2 percent, depending on OACT's estimate of chiropractic expenditures for that calendar year. In order to reflect this fact, we are refining the language in this final rule to indicate that the chiropractic fee codes will be reduced by approximately 2 percent for CYs 2010 through 2014. Additionally, we believe that spreading this adjustment over a longer period of time will minimize its potential negative impact on chiropractic practices.

3. Payment Adjustment

To implement the required BN adjustment, as was proposed (74 FR 33640), we are reducing the payment amount under the PFS for the chiropractic CPT codes (that is, CPT codes 98940, 98941, and 98942). As explained previously, we are finalizing our plans to recoup $10 million each year through adjustments to chiropractic CPT codes for calendar years 2010 through 2014. In order to achieve the $10 million recoupment during such years, payment under the PFS for these codes will be reduced by approximately 2 percent. As stated in prior PFS rules, application of the BN adjustment would be specific to these three codes which represent the ''chiropractic fee schedule'' because they are the only chiropractic codes recognized under the PFS. This methodology also appropriately impacts the chiropractic profession that is directly affected by the demonstration. Consistent with the proposed rule, for this final rule with comment period, we are reflecting this reduction only in the payment files used by the Medicare contractors to process Medicare claims rather than through adjusting the RVUs. Avoiding an adjustment to the RVUs would preserve the integrity of the PFS, particularly since many private payers also base payment on the RVUs. The RVUs published in Addendum B and posted on our Web site will not show this reduction but will be annotated to state that the reduction resulting from the chiropractic demonstration is not reflected in the RVUs.

We received the following comments regarding the methodology used to evaluate BN in the chiropractic services demonstration.

Comment: Instead of the application of an adjustment to the national chiropractor fee schedule, the commenter believes the Congressional intent was for CMS to make an adjustment to the totality of services payable under the Part B Trust Fund because of the language in section 651(f)(A) of the MMA, which directs the Secretary to ''provide for the transfer from the Federal Supplementary Insurance Trust Fund * * * of such funds as are necessary for the costs of carrying out the demonstration projects under this section.''

Response: We disagree that the intent of section 651 of the MMA requires the application of a BN adjustment to the totality of services payable under the Part B Trust Fund. Specifically, section 651(f)(1)(B) of the MMA requires the Secretary to ''ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration projects under this section were not implemented.'' This statutory provision does not specify a particular methodology for ensuring BN, but leaves that decision to the Secretary. Additionally, section 651(f)(1)(A) of the MMA, in pertinent part, provides that ''the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund * * * of such funds as are necessary for the costs of carrying out the demonstration projects under this section.'' This provision merely indicates that payment for the demonstration is to be made from Part B Trust Fund dollars. Section 651(f)(1)(A) of the MMA does not specify in any manner the methodology by which the Secretary is to ensure BN. Consequently, we do not believe it is a mandate requiring the application of an adjustment to the totality of services payable under the Part B Trust Fund.

Comment: The commenter states that more information is necessary to fully understand the findings provided by the evaluator, Brandeis University. The commenter noted that the increase in costs from the demonstration was completely due to the Illinois site, and not the other sites, and that it is ''premature to use demonstration findings to estimate the cost of a national roll out * * * without further investigation of why the Chicago area is such an outlier.'' The commenter also asks how the increase in costs for all neuromusculoskeletal conditions could be causally related to the demonstration project.

Response: Regardless of the differences in the demonstration areas, the evaluation conducted by Brandeis University found that expanding coverage for chiropractic services under the demonstration resulted in increased Medicare expenditures, and the Secretary must recoup these costs in order to meet the BN requirement of the law. The decision to recoup funds is related to the results of the demonstration and the requirement in the law and not to the discussion in the

evaluation report of the costs of a national expansion of coverage.

With respect to the comment questioning how the increase in costs for all NMS conditions could be causally related to the demonstration, we are unsure of what the commenter is asking. If the commenter is asking if Medicare costs associated with all neuromusculoskeletal conditions were used in the evaluation, the response is no, only costs for specific NMS diagnoses that can be treated by chiropractors were included in the evaluation. If the commenter is asking for the rationale for the ''All NMS'' analysis, the response is that this analysis provides a broader view of all of the beneficiaries who would have been eligible for the expanded coverage under the demonstration. This analysis includes beneficiaries with the appropriate neuromusculoskeletal conditions who could have been treated by either a chiropractic physician or other medical physician. The intent-to-treat approach of the ''All NMS'' analysis guards against selection threats to validity. As mentioned previously in this section, we did not base the BN estimate on the ''All NMS'' analysis because it included Medicare beneficiaries who did not use chiropractic services and who would not have become users of chiropractic services even with expanded coverage for them.

K. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues

A Comprehensive Outpatient Rehabilitation Facility (CORF) is a Medicare provider that furnishes respiratory therapy services among other services. In § 485.70, we set forth the personnel qualifications that must be satisfied by a CORF as a condition of participation under § 485.58 and as a condition of coverage of CORF services, including personnel qualifications for respiratory therapists providing CORF respiratory therapy services.

In the CY 2009 PFS proposed rule (73 FR 38502) and subsequent final rule with comment period (73 FR 69942), we revised the definition of a respiratory therapist under § 485.70(j). The change in the definition of respiratory therapist was intended to ensure accuracy in reference to persons who are qualified to perform respiratory therapy and to ensure that language regarding these professionals is consistent with current industry requirements for education, training, and practice.

Prior to its modification by the CY 2009 PFS final rule with comment period, § 485.70(j) reflected the qualifications for Certified Respiratory Therapists (CRTs)'' and ''Registered Respiratory Therapists (RRTs)'' as terms commonly used by the professional industry to identify persons furnishing respiratory therapy services.

Since publication of the CY 2009 PFS final rule with comment, we have been informed by the industry that the changes made in the definition of respiratory therapist exclude a category of professional that has completed the requirements of a CRT, has completed a nationally accredited educational program that confers eligibility for the National Board for Respiratory Care (NBRC) registry exam for respiratory therapists (RTs), and is eligible to sit for the national registry examination administered by the NBRC, but has not yet passed the examination. These persons are referred to in the industry as CRTs.

Because it is our policy that Medicare payment is available for respiratory services provided to Medicare beneficiaries in a CORF only if provided by a respiratory therapist meeting the qualifications set forth in § 485.70(j), payment is not available for respiratory services provided by CRTs in the CORF setting. We note that personnel qualifications for respiratory therapists previously set forth at § 485.70(j) prior to its modification by the CY 2009 PFS final rule with comment period did not exclude this category of personnel from the definition of respiratory therapist. We have also heard from CRTs and from CORFs that this change has limited the availability of respiratory therapy services to Medicare beneficiaries in certified CORFs, as many of these services are provided by CRTs. Thus, in modifying the definition of respiratory therapist in the CY 2009 PFS final rule with comment period, we may have inadvertently impacted access to respiratory therapy services for some Medicare beneficiaries.

Thus, we proposed to modify the definition of respiratory therapist and to clarify the terms that are used to identify those persons who furnish respiratory services in CORFs in § 485.70(j) to include CRTs, that is those individuals who have completed a nationally accredited educational program for respiratory therapists and are eligible to sit for the national registry examination administered by the National Board for Respiratory Care (NBRC), but who have not yet passed the examination. The change in the definition we proposed would permit CRTs to furnish respiratory therapy services to Medicare beneficiaries in the CORF setting.

As proposed, our intent was to assure that persons who were qualified to furnish respiratory therapy services to patients in CORFs prior to the finalization of CY 2009 PFS final rule with comment period (73 FR 69942), will continue to qualify to furnish RT services to CORF patients under this proposed rule.

We solicited public comment on the proposed change to § 485.70(j). We also solicited comments from the industry regarding the difference in services furnished by the different levels of professionals who provide RT services in CORFs.

The following is summary of the comments we received regarding the discussion of the proposed changes to § 485.70(j).

Comment: Commenters expressed strong support for the regulatory changes that we proposed, specifically the clarification of the professional qualifications for respiratory therapists (RTs) in the CORFs setting.

Response: We appreciate support for this regulatory change as we believe it is in the best interest of Medicare and Medicaid beneficiaries. As a result of the comments, we are finalizing these regulatory requirements as proposed.

L. Ambulance Fee Schedule: Technical Correction to the Rural Adjustment Factor Regulations (§ 414.610)

Section 1834(l)(9) of the Act provides that for ''ground ambulance services furnished on or after July 1, 2001, and before January 1, 2004, for which transportation originates in a rural area * * * or in a rural census tract of a metropolitan statistical area * * * the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 17 miles, and up to 50 miles, the rate otherwise established shall be increased by not less than ½ of the additional payment per mile established for the first 17 miles of such a trip originating in a rural area.'' Thus, the statute authorized a rural mileage bonus for miles 18 through 50 for ground ambulance services furnished on or after July 1, 2001 and prior to January 1, 2004. This provision was implemented in § 414.610(c)(5)(i), but the regulation text does not currently specify the statutory time period during which this rural mileage bonus was effective. In the ''Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004'' final rule with comment period (68 FR 67960, 67961), we acknowledged that we inadvertently omitted from the regulation text the time period during which this statutory adjustment was

applicable, and stated we were ''revising § 414.610(c) to reflect that this bonus payment applies only for services furnished during the statutory period.'' Thus, in the ''Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004'' final rule with comment period, we revised the regulation to include the time period during which the adjustment is applicable (68 FR 67963). However, the revised language specifying the statutory time period was dropped inadvertently from the regulation text when § 414.610(c)(5) was later republished in the ''Medicare Program; Medicare Ambulance MMA Temporary Rate Increases Beginning July 1, 2004'' interim final rule (69 FR 40288, 40292).

In this final rule with comment period, we are finalizing our proposal to reinstate the language that was originally finalized in ''Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004'' final rule with comment period (68 FR 67963), but then inadvertently omitted again when § 414.610(c)(5) was later republished, so that § 414.610(c)(5)(i) correctly sets forth the statutory time period during which this rural mileage bonus was applicable. This revision to the regulation is a technical correction to conform the regulation to the statute. For further information, see program instruction, Transmittal AB–03–110; Date August 1, 2003; Change Request 2767 which was issued to inform contractors to discontinue paying such bonuses effective January 1, 2004 in accordance with the statute.

M. Clinical Laboratory Fee Schedule: Signature on Requisition

In the March 10, 2000 **Federal Register**, we published the ''Medicare Program; Negotiated Rulemaking: Coverage and Administrative Policies for Clinical Diagnostic Laboratory Services'' proposed rule (65 FR 13082) announcing and soliciting comments on the results of our negotiated rulemaking committee tasked to establish national coverage and administrative policies for clinical diagnostic laboratory tests under Part B of Medicare. In our final rule published in the November 23, 2001 **Federal Register** (66 FR 58788), we explained our policy on ordering clinical diagnostic laboratory services and amended § 410.32 to make our policy more explicit. Our regulation at § 410.32(a) included the requirement that ''[a]ll diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary.'' In the November 23, 2001 final rule, we added paragraph (d)(2) to § 410.32 to require that the physician or qualified nonphysician practitioner (NPP) (that is, clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, nurse practitioners (NPs), and physician assistants (PAs)) who orders the service must maintain documentation of medical necessity in the beneficiary's medical record (66 FR 58809). In the preamble discussions to the March 10, 2000 proposed rule and November 23, 2001 final rule (65 FR 13089 and 66 FR 58802, respectively), we noted that ''[w]hile the signature of a physician on a requisition is one way of documenting that the treating physician ordered the test, it is not the only permissible way of documenting that the test has been ordered.'' In those preambles, we described the policy of not requiring physician signatures on requisitions for clinical diagnostic laboratory tests, but implicitly left in place the existing requirements for a written order to be signed by the ordering physician or NPP for clinical diagnostic laboratory tests, as well as other types of diagnostic tests. We further stated in the preambles of the proposed and final rules that we would publish an instruction to Medicare contractors clarifying that the signature of the ordering physician is not required for Medicare purposes on a requisition for a clinical diagnostic laboratory test (65 FR 13089 and 66 FR 58802).

On March 5, 2002, we published a program transmittal implementing the administrative policies set forth in the final rule, including the following instruction: ''Medicare does not require the signature of the ordering physician on a laboratory service requisition. While the signature of a physician on a requisition is one way of documenting that the treating physician ordered the service, it is not the only permissible way of documenting that the service has been ordered. For example, the physician may document the ordering of specific services in the patient's medical record.'' (Transmittal AB–02–030, Change Request 1998, dated March 5, 2002).

On January 24, 2003, we published a program transmittal in order to manualize the March 5, 2002 Transmittal. (Transmittal 1787, Change Request 2410, dated January 24, 2003). The cover note to the transmittal states, ''Section 15021, Ordering Diagnostic Tests, manualizes Transmittal AB–02–030, dated March 5, 2002. In accordance with negotiated rulemaking for outpatient clinical diagnostic laboratory services, no signature is required for the ordering of such services or for physician pathology services.'' In the manual instructions in that transmittal in a note, we stated: ''No signature is required on orders for clinical diagnostic services paid on the basis of the physician fee schedule or for physician pathology services.'' The manual instructions did not explicitly reference clinical diagnostic laboratory tests as the cover note did. Rather, the transmittal seemed to extend the policy set forth in the **Federal Register** (that no signature is required on requisitions for clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule) to also apply to clinical diagnostic tests paid on the basis of the PFS and physician pathology services. In addition, the manual instructions used the term ''order'' instead of ''requisition,'' which some members of the industry have asserted caused confusion.

When we transitioned from paper manuals to the current electronic Internet Only Manual system, these manual instructions were inadvertently omitted from the new Benefit Policy Manual (BPM).

In August 2008, we issued a program transmittal (Transmittal 94, Change Request 6100, dated August 29, 2008) to update the BPM to incorporate language that was previously contained in section 15021 of the Medicare Carriers Manual. The reissued language states, ''No signature is required on orders for clinical diagnostic tests paid on the basis of the clinical laboratory fee schedule, the physician fee schedule, or for physician pathology services.'' Based on further review, we have determined that there are no clinical diagnostic laboratory tests paid under the PFS. After Transmittal 94 was published, we received numerous inquiries from laboratory, diagnostic testing, and hospital representatives who had questions about whether the provision applied to all diagnostic services, including x-rays, MRIs, and other nonclinical laboratory fee schedule diagnostic services.

To resolve any existing confusion surrounding the implementation of the policy in 2001 and subsequent transmittals, we restated and solicited public comments on our policy in the CY 2010 PFS proposed rule (74 FR 33641). Our current policy is that a physician's signature is not required on a requisition for clinical diagnostic laboratory tests paid on the basis of the Clinical Laboratory Fee Schedule (CLFS); however, it must be evident, in accordance with our regulations at § 410.32(d)(2) and (3), that the physician ordered the services. The policy that

signatures are not required on requisitions applies to requisitions for clinical diagnostic laboratory tests paid under the CLFS.

We note that we solicited and received comments on this signature requirement during the notice and comment period for the March 10, 2000 proposed rule in the context of our proposal to add paragraph (d)(2)(i) to § 410.32 to require that the practitioner who orders a diagnostic laboratory test must maintain documentation of medical necessity in the beneficiary's medical record. The majority of comments supported the adoption of a policy that the signature of the practitioner on a requisition for a clinical diagnostic laboratory test paid under the CLFS is not the only way of documenting that the test has been ordered and, thus, should not be required provided such documentation exists in an alternate form.

This policy regarding requisitions for clinical diagnostic laboratory tests does not supersede other applicable Medicare requirements (such as those related to hospital Conditions of Participation (CoPs)) which require the medical record to include an order signed by the physician who is treating the beneficiary. Nor do we believe that anything in our policy regarding signatures on requisitions for clinical diagnostic lab tests supersedes other requirements mandated by professional standards of practice or obligations regarding orders and medical records promulgated by Medicare, the Joint Commission, or State law; nor do we believe the policy would require providers to change their business practices.

We also restated and solicited public comment on our long-standing policy consistent with the principle in § 410.32(a) that a written order for diagnostic tests including those paid under the CLFS and those that are not paid under the CLFS (for example, that are paid under the PFS or under the OPPS), such as X-rays, MRIs, and the TC of physician pathology services, must be signed by the ordering physician or NPP. That is, the policy that signatures are not required on requisitions for clinical diagnostic laboratory tests paid based on the CLFS applies only to requisitions (as opposed to written orders) (74 FR 33642).

Additionally, we solicited public comments about the distinction between an order and a requisition (74 FR 33642). We note that an ''order'' as defined in our IOM, 100–02, Chapter 15, Section 80.6.1, is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (for example, if test X is negative, then perform test Y). An order may be delivered via the following forms of communication:

- A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility.
- A telephone call by the treating physician/practitioner or his or her office to the testing facility; or
- An electronic mail, or other electronic means, by the treating physician/practitioner or his or her office to the testing facility.

If the order is communicated via telephone, both the treating physician/practitioner, or his or her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

In the proposed rule (74 FR 33642), we defined a ''requisition'' as the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient. It may contain patient information, ordering physician information, referring institution information, information about where to send reports, billing information, specimen information, shipping addresses for specimens or tissue samples, and checkboxes for test selection. We believe it is ministerial in nature, assisting labs with billing and handling of results, and serves as an administrative convenience to providers and patients. We believe that a written order, which may be part of the medical record, and the requisition are two different documents, although a requisition that is signed may serve as an order. We welcomed comments from the public about the distinction between requisitions and orders.

The following is summary of the comments we received regarding the discussion of the physician signature on requisitions issue.

Comment: We received several comments concerning the fact that a diagnostic test, such as an x-ray, continues to require the signature of the ordering physician or NPP on the written order whether or not the diagnostic test is paid under the CLFS.

Response: We are appreciative that the general public recognized a clear distinction in the proposed rule between clinical diagnostic laboratory tests paid under the CLFS and diagnostic tests that may also be paid under the PFS or OPPS. The discussion in the proposed and final rules this year concerns our current policy that a physician's signature is not required on a requisition for clinical diagnostic laboratory tests paid on the basis of the CLFS. This policy was the result of Negotiated Rulemaking and was outlined in proposed and final rules published during 2000 and 2001, respectively (65 FR 13089 and 66 FR 58790, 58801, and 58802). This policy does not include diagnostic tests such as x-rays.

Comment: One commenter was supportive of both policies on which we solicited comments. Specifically, this commenter supported our policy that a written order for diagnostic tests (including those paid under the CLFS and those that are not paid under the CLFS) must be signed by the ordering physician or NPP. The commenter further stated that the request for a diagnostic test represents part of the physician's plan for the patient, which is part of the patient's medical record. As such, when the request is in writing, a physician signature would be appropriate and likely easily generated. The commenter also supported our policy that a physician's signature is not required on a requisition for clinical diagnostic laboratory tests paid on the basis of the CLFS. The commenter stated that, to the extent a requisition is simply a paper mechanism for transmitting an order and more administrative in nature, it is less likely to be generated or handled by the physician. Thus, to require a physician's signature on a requisition for clinical diagnostic laboratory tests paid on the basis of the CLFS would be an added and unnecessary burden on physicians.

Response: We appreciate the commenter's support of our policies and the commenter's input on these issues.

Comment: Several commenters suggested that we should not require a physician's signature on a medical request, whether that request be an order or a requisition, for any type of test, paid under the CLFS or not, within or outside the hospital setting.

Response: To do as commenters suggest would be a departure from long-standing Medicare policy requiring the physician's signature on written orders in other settings. This procedure serves to document that the physician or NPP ordered the test and documented the medical necessity of the test. The exception of not requiring a physician's signature on the requisition for a clinical diagnostic laboratory test paid under the CLFS only is very narrow and does not include other types of tests paid in other types of settings.

Comment: Several commenters raised concerns about issues relating to electronic medical records. Specifically, commenters were concerned whether or not an electronic signature would be acceptable and had questions about what constitutes a medical record in a paperless environment. One commenter stated that, generally, electronic systems that are used to request laboratory testing can be used by physicians with authorized access only and that as a result, a physician's signature should not be expected or required.

Response: We appreciate the commenters' concerns about these issues. CMS is in the process of developing guidelines concerning electronic records and electronic signatures for use in CMS programs. These guidelines will be finalized at a later date. The general public will be kept apprised of our progress on this issue through future official issuances.

Comment: One commenter urged us to establish a ''rule of reason'' with regard to what is required to be in the medical record, while two other commenters provided detailed suggestions on how to improve our manual language in this regard. These commenters were concerned about the fact that physicians sometimes make shorthand notes or indicate that there was an office visit only without further details in the medical record concerning the specific laboratory tests that are ordered.

Response: We believe that, whenever a physician orders services, including laboratory tests, for a patient in order to assist in diagnosing or treating the patient's conditions, the ordering of those services should be documented in the patient's medical record. Nonetheless, we do appreciate the commenters' concerns about the scope of the medical record and efforts to make detailed suggestions about how to improve the direction provided in our manuals. We will carefully consider these issues and if we decide that further clarification is warranted, will issue such clarification.

Comment: Several commenters were concerned that, while documentation to support an unsigned requisition would be required to be maintained in the medical record, employees at the clinical diagnostic laboratory do not have access to the medical record to verify whether or not this documentation exists. Commenters stated that, once a laboratory receives an order or requisition, it is obligated to perform the test as quickly as possible because it is in the best interest of the Medicare beneficiary, regardless of whether or not a physician signature is present. Commenters also raised the issue of fragility of the specimen and that it is essential to complete testing as soon as possible before the specimen begins to degrade. Commenters were concerned about being obligated to ensure that orders maintained in the physician's office were signed prior to being able to perform the test in the laboratory. The commenters do not believe that this obligation is fair to them or the Medicare patient as access to essential information could be delayed or compromised. Conversely, another commenter recommended that, in addition to the affirmation by the physician in the medical record that the laboratory test had been ordered, the laboratory should be required to close the loop and provide documentation that the test had been performed for inclusion in the medical record as well.

Response: We recognize that, without the physician's signature on the requisition, some clinical diagnostic laboratories believe it is burdensome to verify that the request for services is valid. However, our regulations at § 410.32(d)(2)(iii) provide the entity submitting the claim (that is, the clinical diagnostic laboratory) with the option to request additional diagnostic and other medical information to document that the services it bills are reasonable and necessary.

Comment: Several commenters believe that the signature issue is burdensome because multiple physician services can be requested on the same form, and, in such cases, one service might require the physician's signature while another might not. For example, it is possible that both the Technical Component (TC) of physician pathology services and clinical laboratory services may appear on the same requisition and that it would be confusing to have one set of requirements for clinical diagnostic laboratory tests and a different set of requirements for physician pathology services. Physicians may not know whether a particular laboratory or pathology test is paid under the CLFS or the PFS. The commenters suggested that we further clarify our policy to address this particular issue. We received a number of comments specifically requesting that we develop a single policy for all outpatient laboratory services, without distinction for those paid under the CLFS or the PFS.

Response: We appreciate the commenters' concerns. We will examine options for creating a fair and consistent policy regarding signatures that will address situational needs.

Comment: Several commenters stated that we needed to draw a clearer distinction between a requisition and an order, as they did not understand the difference between them. Commenters also suggested that, as medical records move to an electronic format, this distinction becomes more difficult to describe.

Response: We agree with the commenters' interest in having clear and concise distinctions between ''requisition'' and ''order'' especially as we move toward electronic means of record keeping and communication. We asked for comments about how to define a requisition, and we did receive some helpful suggestions. At this time, we are not addressing the specific comments on the distinction between orders and requisitions. We will continue to develop clearer direction on this issue, taking into consideration the suggestions submitted by commenters.

Comment: One commenter was concerned that physicians are signing stacks of laboratory requisition forms in advance of their use, or using a pre-signed hand stamp to make a requisition form official. The commenter stated that we did not draw a distinction between requisitions signed in advance and requisitions signed at the point of service for a specific purpose in the presence of the patient.

Response: We appreciate that the commenter brought these real world procedures to our attention. We will review this issue and consider it in the future as we consider all the issues that were brought to our attention through the proposed rulemaking effort this year.

Comment: We received several comments concerning the date of service (DOS) rule in reference to performing clinical diagnostic laboratory tests on stored specimens which were collected from the patient during the time that he/she was an inpatient at a hospital.

Response: We thank the commenters for their concerns on this issue. However, since we have not proposed any changes to the DOS rule at this time, we will not be addressing this comment in this final rule as these comments are outside the scope of our proposals for CY 2010.

In light of the issues and concerns raised during the comment period, and our desire to create policy that will address the concerns in a meaningful, clear, and thoughtful way, we will continue to carefully consider the issues of physician signatures on requisitions and orders. We plan to revisit these issues in the future paying particular attention to the definition of order and requisition.

N. Physician Self-Referral

1. General Background

Section 1877 of the Act, also known as the physician self-referral law, prohibits the following: (1) a physician from making referrals for certain designated health services (''DHS'') payable by Medicare to an entity with which he or she (or an immediate family member) has a direct or indirect financial relationship (an ownership/investment interest or a compensation arrangement), unless an exception applies; and (2) the entity from presenting or causing a claim to be presented to Medicare (or billing another individual, entity, or third party payor) for those referred services. The statute establishes a number of exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that pose no risk of program or patient abuse.

In the proposed rule, we proposed to clarify § 411.354(c)(3)(i) regarding the application of certain exceptions to arrangements in which a physician stands in the shoes of his or her physician organization. In section II.N.2. of this final rule with comment period, we respond to public comments on this proposal and finalize it without change.

In the FY 2009 IPPS final rule (73 FR 48721), we revised the definition of ''entity'' to include any person or entity that has ''performed services that are billed as DHS.'' In section II.N.3 of this final rule with comment period, we solicit comments regarding whether we should issue further guidance on what constitutes performing services billed as DHS and if so, the nature or content of such guidance.

2. Physician Stand in the Shoes

Determining whether an entity furnishing DHS and a physician have a direct or indirect compensation arrangement is a key step in applying the statute because it affects which compensation exceptions may apply to the arrangement. Section 411.354(c) governs when a physician ''stands in the shoes'' of his or her physician organization and may therefore, depending on the circumstances, have a direct, rather than an indirect, compensation arrangement with an entity furnishing DHS.

Our proposal (74 FR 33643) sought to clarify one aspect of the physician stand in the shoes provisions at § 411.354(c). Specifically, we proposed to clarify the second sentence of § 411.354(c)(3)(i) to provide that, ''[w]hen applying the exceptions in § 411.355 and § 411.357 of this part to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated 'between the parties' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).''

Section 411.354(c)(3)(i) addresses the application of the general exceptions to the referral prohibition related to both ownership/investment and compensation (§ 411.355) and the exceptions to the referral prohibition related to compensation arrangements (§ 411.357), to arrangements in which a physician stands in the shoes of his or her physician organization. Many of these exceptions require the arrangement to be in writing and signed by the parties and prohibit the compensation from taking into account the volume or value of referrals or other business generated by the referring physician.

Under § 411.354(c)(3)(i), a physician who stands in the shoes of his or her physician organization is deemed to have the same compensation arrangements with the same parties and on the same terms as the physician organization. The second sentence of § 411.354(c)(3)(i) provides that ''[f]or purposes of applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the 'parties' to the arrangements are considered to be the entity furnishing DHS and the physician organization (including all members, employees, or independent contractor physicians).''

After the publication of Phase III, some members of the industry questioned whether the second sentence of § 411.354(c)(3)(i) defined the term ''parties'' everywhere it appears in the physician self-referral regulations, including the requirement in many exceptions that a compensation arrangement be in writing and ''signed by the parties.'' Consequently, these members believed it was necessary for everyone within a physician organization (that is, all members, employees, and independent contractor physicians) to sign a myriad of different arrangements with an entity furnishing DHS. This was not our intent. In January 2008, we posted a frequently asked question (FAQ) on our Web site to explain that ''we consider a physician who is standing in the shoes of his or her physician organization to have signed the written agreement when the authorized signatory of the physician organization has signed the agreement.'' After the FY 2009 IPPS final rule, under which only physician owners are deemed to stand in the shoes of their physician organizations, some industry representatives questioned whether physicians who did *not* stand in the shoes remained ''parties'' under § 411.354(c)(3)(i) and, would therefore, need to become signatories to any compensation arrangement that was required to be in writing and ''signed by the parties.''

We proposed to clarify the second sentence of § 411.354(c)(3)(i) to provide that, ''[w]hen applying the exceptions in § 411.355 and § 411.357 of this part to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated 'between the parties' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).''

Our proposed change clarifies that we are not defining the term ''parties'' and should eliminate any possible public misconception that all physicians in a physician organization (whether or not they stand in the shoes of the physician organization) must sign the writing(s) memorializing a compensation arrangement between their physician organization and an entity furnishing DHS. Furthermore, we note that some members of the industry have erroneously applied the second sentence of § 411.354(c)(3)(i) by analyzing whether the compensation takes into account the referrals between the entity furnishing DHS and the physician who stands in the shoes of the physician organization *only,* not the referrals of all members, employees, and independent contractor physicians in the physician organization. The revised regulation reiterates that the relevant referrals and other business generated between the physician organization and the entity furnishing DHS are the referrals of all physicians in the physician organization (including all members, employees, and independent contractors), not simply the referrals made by each physician who stands in the shoes of the physician organization.

We solicited public comments regarding our proposal and alternative approaches to address this issue. We received five public comments that related to our proposal which supported our proposal. After consideration of the public comments received, we are adopting our proposal unchanged. We are revising the second sentence of § 411.354(c)(3)(i) to provide that, ''[w]hen applying the exceptions in § 411.355 and § 411.357 of this part to arrangements in which a physician

stands in the shoes of his or her physician organization, the relevant referrals and other business generated 'between the parties' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).'' We believe the finalized language clarifies the regulation text and is consistent with our intent to minimize the potential for abuse without imposing undue burden on the provider community. We address below the specific comments that we received in response to our proposal in the CY 2010 proposed rule.

Comment: The commenters supported the clarification to the physician stand in the shoes provision. Several commenters appreciated that we clarified that not all physicians in a physician organization must sign documents memorializing a compensation arrangement between their organization and a DHS entity. One commenter stated that it is beneficial to consider a physician to have signed the written agreement if the agreement is signed by the organization's authorized signatory.

Response: The commenters' responses supported the approach we took in the proposed rule. Thus, as stated above, we are revising § 411.354(c)(3)(i) to state that when applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated ''between the parties'' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians). With regards to deeming a physician to have signed the written agreement, our revision of the regulation text to avoid the appearance of defining the word ''parties,'' eliminates the need to consider any particular physician to have signed an agreement that he or she did not actually sign.

3. Services Provided ''Under Arrangements'' (Services Performed by an Entity Other Than the Entity That Submits the Claim): Solicitation of Comments

Under section 1877(a)(1)(A) of the Act, if a physician (or an immediate family member) has a financial relationship with an ''entity,'' it may not make a referral to the entity for the ''furnishing'' of DHS, unless the financial relationship meets an exception. In the Phase I final rule, we defined the term ''entity'' at § 411.351 and specified that ''a person or entity is considered to be furnishing DHS if it is the person or entity to which [Medicare] makes payment.'' Thus, under the Phase I rule, only the person or entity that billed Medicare for the DHS was considered the DHS ''entity,'' and not the person or entity that actually performed the DHS (where that person or entity was not the person or entity billing for it) (66 FR 953). In the CY 2008 PFS proposed rule (72 FR 38186 through 38187, 38219, and 38224), we expressed concern that the Phase I definition of ''entity'' might permit certain abusive agreements for services provided under arrangements with hospitals and other providers. Based upon our concerns about overutilization, corruption of medical judgment and other abuse, we proposed to revise the definition of ''entity'' at § 411.351 to include ''the person or entity that has performed the DHS''.

In the FY 2009 IPPS final rule (73 FR 48434 and 48729), we stated our belief that, in some instances, hospitals would prefer to furnish services directly but have been concerned about losing referral streams if they compete with physician service providers. Very few comments submitted by hospitals objected to our proposed revision to the definition of entity, and, instead, two major hospital associations were generally supportive of it. Some physician commenters asserted that hospitals are risk averse to bringing services to communities. We questioned whether physicians are less risk averse because they can control the referral stream. We stated that hospitals may be more concerned about risk because they fear that referrals will go to their competitors if they do not enter into contractual arrangements with physician groups. Finally, we stated that ''our proposal as finalized will create a more level playing field between hospitals and physicians and also among hospital competitors.''

In that rule, we finalized the proposal by amending the definition of entity at § 411.351 to specify that an entity furnishing DHS includes the person or entity that has presented a claim to Medicare for the DHS as well as any person or entity that has ''performed services that are billed as DHS,'' notwithstanding that another person or entity actually billed the services as DHS.

Commenters to the proposed rule expressed concern regarding the potential ambiguity of the meaning of ''performs.'' We declined to provide a specific definition of ''performed services that are billed as DHS,'' but stated the following in response to one of the commenters:

> By way of example only, we consider a service to have been ''performed'' by a physician or physician organization if the physician or physician organization does the medical work for the service and could bill for the service, but the physician or physician organization has contracted with the hospital and the hospital bills for the service instead * * *. We do not consider an entity that leases or sells space or equipment used for the performance of the service, *or* furnishes supplies that are not separately billable but used in the performance of the medical service, *or* that provides management, billing services, *or* personnel to the entity performing the service, to perform DHS. (73 FR 48726, emphasis added).

We delayed the effective date of the amendment to the definition of ''entity'' until October 1, 2009, in order to afford parties an adequate time to restructure arrangements (73 FR 48723).

We assume that health care providers have restructured their arrangements to come into compliance with the new rule by the October 1, 2009 effective date. We have received numerous inquiries regarding whether we plan to issue additional guidance on the revised definition of entity, including the meaning of ''performed services that are billed as DHS.'' We continue to believe that the changes set forth in the FY 2009 IPPS final rule effectuated our intent to minimize overutilization and anti-competitive behavior and, as such, we decline to issue a specific proposal concerning the definition of entity at this time. In order to keep abreast of the views of industry stakeholders, we are soliciting comments to determine if further guidance is necessary and, if so, what clarification(s) may be beneficial to the industry in interpreting and applying the changes finalized in the FY 2009 IPPS final rule. Therefore, we are interested in receiving comments on the following:

- Whether we should define or clarify ''performed services that are billed as DHS,'' and, if so, how.
- Whether ''performed services that are billed as DHS'' should be analyzed in the same manner for inpatient and outpatient services provided under arrangements.
- Whether performance of a service billed as DHS should be determined based on how many of the following elements are provided: (1) Lease of space used for performance of the service; (2) lease of equipment used for the performance of the service; (3) supplies that are not separately billable but used in the performance of the service; (4) management services; (5) billing services, and (6) nonphysician services that are not separately billable.

If so, whether certain of these elements should be weighed more heavily than others in determining whether DHS are performed.

• Whether an interpretation of ''medical work'' was relied upon in restructuring arrangements and, if so, how.

• The degree to which the amount and nature of services provided by physician and nonphysician personnel (for example, technicians) should influence the determination of whether a person or organization has performed services billed as DHS.

• The degree to which the ability to bill separately for the service should influence the determination regarding whether a person or organization has ''performed services that are billed as DHS.''

• Whether there are other comments or alternative approaches or criteria that would address our policy concerns about overutilization and other abuse while minimizing the impact on legitimate non-abusive arrangements.

We welcome any information concerning how the industry interpreted and applied the definition of entity and how under arrangement agreements may have been restructured in order to comply with the new definition of entity at § 411.351.

O. Durable Medical Equipment-Related Issues

1. Damages to Suppliers Awarded a Contract Under the Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (Medicare DMEPOS Competitive Bidding Program) Caused by the Delay of the Program

Section 1847 of the Act, as amended by section 302(b)(1) of the MMA, requires the Secretary to establish and implement a Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP). On July 15, 2008, the MIPPA was enacted. Section 154 of the MIPPA amended section 1847 of the Act to make certain limited changes to the competitive bidding program, including adding a new subsection (a)(1)(D) to section 1847 of the Act. Section 1847(a)(1)(D) terminates retroactively the competitive bidding contracts that were awarded to suppliers in 2008 for the Round 1 of competitive bidding and prohibits payment based on such contracts. Section 154 of the MIPPA effectively reinstated payment for competitively bid items and services to the Medicare fee schedule amounts, as set forth in section 1834 of the Act and 42 CFR part 414, subpart D of our regulations.

Section 1847(a)(1)(D)(i)(I) of the Act, as amended by the MIPPA, stipulates that to the extent any damages may be applicable as a result of the termination of contracts, payment is to be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Act. Section 1847(a)(1)(D) of the Act also states that nothing in section 1847(a)(1)(D)(i)(I) of the Act, which includes the reference to damages, shall be construed to provide an independent cause of action or right to administrative or judicial review with the regard to the termination of the Round 1 contracts.

For further discussion of the Competitive Bidding Program and the bid evaluation process, see the Medicare Program; Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Other Issues final rule published in the April 10, 2007 **Federal Register** (72 FR 17992) and the Medicare Program; Changes to the Competitive Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) by Certain Provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) interim final rule with comment period (IFC) published on January 16, 2009 **Federal Register** (74 FR 2873).

We proposed to add new § 414.425 to establish a process to evaluate any claims for damages caused by the termination of contracts awarded in early 2008 under the DMEPOS CBP that were terminated as a result of section 154(a)(1)(A)(iv) of the MIPPA.

We offered contracts in March 2008 to selected suppliers for the first round of the DMEPOS CBP. The contracts that were accepted were terminated by the MIPPA retroactive to June 30, 2008. We considered the terms of the contracts and other processes of the DMEPOS CBP as we developed this proposed process to determine, on a case-by-case basis, whether to award damages and, where applicable, the amount of damages to be awarded for the termination of these contracts.

When considering whether to submit a claim for damages, suppliers may consider the following factors:

• Each contract stipulated that the contract is subject to any changes to the statute or regulations that affect the Medicare program.

• Each contract indicated CMS does not guarantee any amount of business or profits.

• Each contract stipulated that CMS shall not pay for any expenses incurred by the supplier for the work performed under the contract other than for payment of Medicare claims authorized under the contract.

• Upon termination of the contracts by the MIPPA, payments reverted to the CY 2008 fee schedule amount, which was on average 26 percent higher than payment amounts under the DMEPOS CBP.

• We will review a supplier's estimated and historic capacity and any expansion plans that were submitted as part of a supplier's bid.

• We will review a supplier's action to meet its obligation to mitigate its damages.

• We listed the winning suppliers on the Medicare.gov Web site in the supplier locator tool; a supplier is allowed to keep any new customers they may have obtained because of being listed on the supplier locator tool.

• This list is not intended to suggest that there are not legitimate claims for damages. However, these are factors that a supplier may consider when deciding whether to submit a claim for damages.

The proposed provisions outline the information that suppliers would need to provide when submitting claims for damages and the process that we would follow to review these claims. The information we proposed to collect from suppliers is necessary for us to make a reasonable decision on whether damages are warranted and how much in damages should be awarded. We believe that the process is not overly burdensome to those suppliers choosing to participate in this review process and would ensure a thorough review of a supplier's claim for damages.

We proposed the following process to file a claim for damage claims:

a. Eligibility To File a Claim

Any aggrieved supplier that was awarded a contract in March 2008 for the Round 1 DMEPOS CBP and believes it has suffered damages is eligible to submit a claim. The supplier must be able to demonstrate how its company was damaged. These damages must be substantiated and be as a direct result of the termination by MIPPA of their Round 1 DMEPOS CBP contract. Only a contract supplier, and not a subcontractor of a contract supplier, is eligible to submit a claim for damages.

Comment: One commenter stated that although CMS has no direct obligation to subcontractors, CMS should allow contract suppliers to include in their claims the damages incurred by their subcontractors.

Response: We disagree with the commenter's statement that we should consider the damages incurred by

subcontractors because the contract is between CMS and the contract supplier. We believe the extent of our obligation should only consider damages realized by the contract supplier. However, should a contract supplier realize damages due to their arrangement with a subcontractor those damages may be included if they are directly attributable to the Round 1 terminations. We do not believe that the language of MIPPA extends beyond the original contract arrangements between CMS and contract suppliers, as required by the MMA.

After consideration of the public comments we received, we are not making any changes to the proposed process for awarding damages for contracts terminated under the MIPPA.

b. Timeframes for Filing a Claim

A completed claim, including all documentation described below in section II.O.1.c., must be filed within 90 days of January 1, 2010, which is the effective date of these damages provisions, unless the 90th day is a weekend or Federal holiday. In that case, the last date to file a claim will be the day following the weekend or Federal holiday. The date of filing is the actual date of receipt by the Competitive Bidding Implementation Contractor (CBIC) of a completed claim from the supplier that includes all of the information required by this rule. We strongly urge claimants to use a tracking method such as with the United States Postal Service or a carrier that requires a return receipt that indicates the date on which the claim was delivered.

We did not receive any comments on this section of the proposed process for awarding damages for contracts terminated under the MIPPA. Therefore, we are finalizing these provisions as proposed with a minor change by adding the effective date of these damages provisions.

c. Information That Must Be Included in a Claim

At a minimum, a claim should include all of the following:

- Supplier's name and bidding number.
- Supplier's current contact information (Name of authorized official, U.S. Post Office mailing address, phone number and e-mail address).
- A copy of the DMEPOS CBP Round 1 contract(s) the supplier signed with CMS.
- A detailed explanation of the damages incurred by the supplier. The explanation must document the supplier's damages through receipts and records that establish the claimant's damages directly related to meeting the terms of the DMEPOS CBP Round 1 contract.
- The supplier must also explain how it would be damaged if not reimbursed.
- A detailed explanation of the steps of all attempts to use for other purposes, return, or dispose of equipment or other assets purchased or rented for use in the Round 1 DMEPOS CBP contract performance.

Damages claimed must be specifically related to carrying out the terms of the contract, and may include, but are not limited to, the following:

- Items or equipment purchased or rented and dates of such rental or purchases.
- Additional employee costs.
- Additional inventory costs.
- Additional facility costs.

The supplier must include a separate justification for any of these items for which it is claiming damages and explain how they were necessary to meet the deadline of July 14, 2008 of the Round 1 DMEPOS CBP contract. This does not include expenses that would have occurred if the supplier had not been awarded a contract but only those expenses that were incurred for the Round 1 DMEPOS CBP contract performance. The claim must also detail steps taken by the supplier to mitigate damages that they may have incurred due to the contract termination.

In addition, we are not considering claims for expenses incurred prior to March 20, 2008, including the purchase or rental of items or equipment before that date, because a supplier would not have known that it was going to be offered a contract. We are not considering claims for most expenses incurred after July 14, 2008, including the purchase or rental of items or equipment, because this is the date on which MIPPA terminated all of the Round 1 contracts. The only exception to this requirement would be for expenses incurred to mitigate damages associated with the termination of the Round 1 contracts.

Comment: One commenter suggested that CMS should not exclude costs incurred prior to March 20, 2008 and after July 14, 2008.

Response: We disagree with the commenter. We first notified suppliers on March 20, 2008, that they were being offered a contract. We are not considering claims for expenses incurred prior to March 20, 2008, because a supplier would not have known that it was going to be offered a contract before that date. We are also not considering claims for most expenses incurred after July 14, 2008, including the purchase or rental of items or equipment, because this is the date on which MIPPA terminated all of the Round 1 contracts.

Comment: One commenter suggested that CMS should include costs incurred in preparing or submitting a claim for damages.

Response: We disagree with the commenter. Any damages awarded under this contract only include costs incurred in carrying out the terms of the contract. The cost of submitting a claim for damages is not a cost that is incurred in carrying out the terms of the contract. Suppliers must weigh the cost of filing a claim for damages against damages they believe they incurred.

Comment: One commenter suggested that CMS should include consulting and legal expenses required to submit a bid in the competitive bidding program.

Response: We disagree. Suppliers could have incurred these costs even if they were not awarded a contract. The MIPPA provision pertains to damages that were the result of the termination of the contract and not the cost of applying for the contract. This does not include expenses that would have occurred if the supplier had not been awarded a contract but only those expenses that were incurred for the Round 1 DMEPOS CBP contract performance. Damages claimed must be specifically related to carrying out the terms of the contract.

Comment: One commenter suggested that CMS should allow suppliers to amend a claim deemed incomplete by the CBIC.

Response: We disagree with the commenter. The proposed rule describes what constitutes, at a minimum, a complete claim. While all claims for damages will be considered, there is certain minimum information that has to be submitted with the claim in order for the claim to be processed. Without this information we will not be able to process the claim. We believe that 90 days is sufficient time for the supplier to submit a completed claim. This provides an equal amount of time for all suppliers filing a claim for damages to submit their claim.

Comment: One commenter suggested that CMS should not exclude from damages ''costs that the supplier has recouped by any means''.

Response: We disagree with the commenter. We believe that all parties to a contract are obligated to take action to mitigate any damages and to describe the steps they have taken to meet this obligation. For example, if a supplier purchases inventory to carry out the terms of the contract and later uses this inventory for other Medicare

beneficiaries, in effect the Medicare program would be charged twice for the same item, if it were to include these costs in an award for damages. Each supplier has an obligation to mitigate, as far as possible, damages associated with the termination of its Round 1 contract(s).

After consideration of the public comments we received, we are not making any changes to this section of the proposed process for awarding damages for contracts terminated under the MIPPA.

e. Filing a Claim

Suppliers should submit claims, with all supporting documentation, with the CMS CBIC at the following address: CBIC; Bldg 200, Suite 400; 2743 Perimeter Parkway; Augusta, Georgia 30909. The authorized official for the supplier must certify the accuracy of the information on the claim and all supporting documentation. The authorized official is appointed by the supplier and has the legal authority granted by the supplier to submit the claim for damages. This person may be the supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of the supplier organization, or must hold a position of similar status and authority within the supplier's organization. The CBIC will not accept electronic submissions of claims for damages.

Comment: Several commenters recommended that CMS allow suppliers who are dissatisfied with CMS' decision to obtain an independent administrative review of the determination for damages under this process.

Response: We disagree with the commenter. The statute does not provide for review of such determinations. Section 1847(a)(1)(D) of the Act, as amended by section 154(a)(1)of MIPPA does not provide for administrative or judicial review of the Determining Authority's decision. Section 1847(a)(1) of the Act, as revised by section 154(a) of the MIPPA, terminated the contracts that were awarded under the competitive acquisition program, and provided that such termination and award of damages should not be construed to provide an independent cause of action or right to administrative or judicial review. Therefore, the Determining Authority's final decision is not subject to administrative or judicial review.

Comment: One commenter recommended that CMS should identify who within CMS will be tasked with the reviews and the standards that will apply to requests for claims.

Response: We will utilize the necessary resources within the agency to make these decisions. We will be utilizing the expertise from various components within CMS, such as the Office of Acquisition and Grants Management, Office of Financial Management and the Office of the General Counsel in the Department of HHS as necessary. An Agency official who is a senior executive and who has responsibility for the competitive bidding program will be designated as the Determining Authority.

After consideration of the public comments, we are not making any changes to this section of the proposed process for awarding damages for contracts terminated under the MIPPA.

f. Review of Claim

(1) Role of the CBIC

The CBIC will conduct the first level of review and make recommendations to CMS, hereafter referred to as the Determining Authority regarding:

- Whether the claim is complete and was filed in a timely manner. The CBIC may seek further information from the claimant when making its recommendation. The CBIC may set a deadline for receipt of additional information.
- When the claim is incomplete or was not filed in a timely manner, the CBIC will make a recommendation to the Determining Authority not to process the claim further.
- Whether the government owes damages because of the MIPPA. The CBIC will include an explanation supporting its recommendation. The CBIC will recommend a reasonable amount of damages, if any, based on the claim submitted, including all accompanying documentation. The CBIC will consider the language of the contract, as well as both costs incurred and the contract supplier's attempts and actions to limit the damages.

(2) CMS' Role as the Determining Authority

CMS is the Determining Authority because we are responsible for the final review and final determination regarding claims for damages.

- The Determining Authority shall review the recommendation of the CBIC.
- The Determining Authority may seek further information from the claimant or the CBIC in making a concurrence or non-concurrence determination.
- The Determining Authority may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.
- If the Determining Authority concurs with the CBIC recommendation, the Determining Authority shall submit a final signed decision to the CBIC and direct the CBIC to notify the claimant of the determination and the reasons for the final determination.
- If the Determining Authority nonconcurs with the CBIC recommendation, the Determining Authority may:

+ Write a determination granting (in whole or in part) a claim for damages or denying a claim in its entirety; or direct the CBIC to write said determination for the Determining Authority's signature.

+ Return the claim to the CBIC with further instructions.

- The Determining Authority's determination is final and binding; it is not subject to administrative or judicial review under section 1847(a)(1)(D) of the Act, as amended by section 154(a)(1) of the MIPPA.

Comment: Several commenters suggested that an additional step be included to permit affected suppliers to cure technical and other deficiencies in their claim.

Response: We do not agree with the commenters. Claimants are required to submit a complete claim in a timely manner. CMS stated in the rule that either the CBIC or CMS as the Determining Authority may seek further information from the claimant concerning the claim. This does not mean that claimants will have an opportunity to provide additional information after the deadline for filing has ended, unless requested to do so by the CBIC or CMS.

After consideration of the public comments, we are not making any changes to this section of the proposed process for awarding damages for contracts terminated under the MIPPA.

g. Timeframe for Final Determinations

Every effort will be made to make a final determination within 120 days of initial receipt of the claim for damages by the CBIC or the receipt of additional information that was requested by the CBIC, whichever is later. In the case of more complex cases, or in the event of a large workload, a decision will be issued as soon as practicable.

We did not receive any comments on this section of the proposed process for awarding damages for contracts terminated under the MIPPA. Therefore, we are finalizing the provisions as proposed.

h. Notification to Claimant of Damage Determination

The CBIC shall mail the final determination to the claimant by

certified mail return receipt requested. If CMS determines that money is due to a claimant, this notification will indicate when and how the money will be transmitted. If a monetary award is due, the supplier will be required to provide banking information for electronic deposit.

We did not receive any comments on this section of the proposed process for awarding damages for contracts terminated under the MIPPA. Therefore, we are finalizing these provisions as proposed.

We are finalizing the provisions concerning damages as proposed in the CY 2010 PFS proposed rule (74 FR 33644).

2. Notification to Beneficiaries for Suppliers Regarding Grandfathering

Section 1847(a)(4) of the Act requires that in the case of covered durable medical equipment (DME) items for which payment is made on a rental basis under section 1834(a) of the Act, and in the case of oxygen for which payment is made under section 1834(a)(5) of the Act, the Secretary shall establish a ''grandfathering'' process under which rented DME items that were furnished prior to the start of the Competitive Bidding Program (CBP) may be continued to be rented to the beneficiary by a noncontract supplier. Agreements for those covered items and supplies that were rented by the supplier to the beneficiary before the start of a CBP may be continued, regardless of whether the existing supplier participates in the CBP.

In the April 10, 2007 final rule (72 FR 17992), in § 414.408(j), we established the grandfathering process described below for rented DME and oxygen and oxygen equipment when these items are included under the Medicare DMEPOS CBP. A supplier that is furnishing DME or is furnishing oxygen or oxygen equipment on a rental basis to a beneficiary prior to the implementation of a CBP in the competitive bidding area (CBA) where the beneficiary maintains a permanent residence may elect to continue furnishing the item as a grandfathered supplier. This process only applies to suppliers that began furnishing the competitive bid items described above before the start of the CBP to beneficiaries who maintain a permanent residence in a CBA.

In the case of the rented DME and oxygen and oxygen equipment identified in this section, we established in § 414.408(j)(4) that Medicare beneficiaries have the choice of deciding whether they would like to continue receiving the rented item from a grandfathered supplier or if they would like to receive the item from a contract supplier.

Suppliers that agree to be a grandfathered supplier for an item must agree to be a grandfathered supplier for all current beneficiaries who request to continue to rent that item from them. The beneficiary's decision to use a grandfathered supplier depends on the decision of the noncontract supplier that is currently renting the competitive bidding item to continue renting the item as a grandfathered supplier after the start of the CBP in accordance with the terms we have specified. The payment rules for grandfathered suppliers are specified in existing § 414.408(j)(2).

In addition, the beneficiary may elect, at any time, to transition from a noncontract supplier to a contract supplier. The contract supplier would be required to accept the beneficiary as a customer regardless of how many rental months had already been paid for the beneficiary to receive this item. If the grandfathered supplier is not willing to continue furnishing the item, a beneficiary must select a contract supplier to furnish the item in order to receive Medicare payment for that item. The grandfathered supplier is paid based on the payment rules outlined in the final rule on Competitive Bidding at § 414.408(j).

As a result of what we learned from Round 1 of the CBP, we proposed changes to the ''grandfathering'' rules by establishing notification requirements for noncontract suppliers that are furnishing rented DME competitive bid items at the time of implementation of the CBP in the CBA in which the beneficiary resides. We also proposed a new definition for a grandfathered item to include all rented item(s) in a competitive bidding product category that a supplier currently provides to its beneficiaries. Under the current regulation, suppliers may choose the items within a product category for which they want to become a grandfathered supplier.

As proposed, a noncontract supplier would have to choose to be either a grandfathered supplier for all or for none of the rented DME items within a product category that the supplier currently provides.

For further discussion of the CBP and the bid evaluation process, see the April 10, 2007 final rule and the January 16, 2009 interim final rule with comment period.

We proposed to revise the definition of ''grandfathered item'' in § 414.402 so that the term would refer to all rented items within a competitive bid product category that the supplier currently rents to beneficiaries. In addition, we proposed to redesignate the current § 414.408(j)(5) as § 414.408(j)(7) and add new § 414.408(j)(5) and (j)(6). The new § 414.408(j)(5) and (j)(6) will specify the notification requirements that apply to noncontract suppliers that are renting DME competitive bid items in a CBA at the time of implementation of the CBP.

a. Definition of a Grandfathered Item

We proposed to revise the definition of a ''grandfathered item'' in § 414.402 to avoid confusion, on the part of beneficiaries, regarding rented DME items for which a noncontract supplier is willing or not willing to be a grandfathered supplier. Under the current regulations, a supplier may make separate choices regarding grandfathering for each individual HCPCS code. For example, a supplier may choose to be a grandfathered supplier for a particular type of walker within the product category instead of all of the walkers included in that product category that are furnished on rental basis.

Under the revised definition, a noncontract supplier would have to choose to be either a grandfathered supplier for all or for none of the DME rented items within a product category that the supplier currently provides. We believe that it would be easier for beneficiaries to recognize which items a supplier is grandfathering or not grandfathering if the supplier's election concerning grandfathering was made by product category rather than making separate choices for each individual HCPCS code. In addition, this proposed revision would prevent suppliers from choosing to be a grandfathered supplier for only the more profitable items, which could disadvantage certain beneficiaries.

Comment: One commenter stated that CMS should allow noncontract suppliers to furnish and bill for supplies, such as CPAP masks, for ''capped'' rental equipment, as well as, supplies for rental equipment that they have chosen to grandfather.

Response: Section 1847(a)(4) of the Act only refers to DME items for which payment is made on a rental basis under section 1834(a) of the Act. Therefore, grandfathering can only apply to those items and necessary accessories and supplies provided during the rental period. Once the rental period ends additional accessories and supplies must be provided by the contract supplier.

Comment: Several commenters suggested that CMS should expand the grandfathering provisions to all

products including diabetic testing supplies subject to the CBP.

Response: Section 1847(a)(4) of the Act only refers to DME items for which payment is made on a rental basis under section 1834(a) of the Act. Therefore, we cannot extend grandfathering provisions to items that are not DME or not paid on a rental basis.

After consideration of the public comments we received, we are not making any changes to this section of the proposed rule.

b. Notification of Beneficiaries and CMS by Suppliers That Choose To Become Grandfathered Suppliers

We proposed to add a new § 414.408(j)(5)to require suppliers furnishing items to be included in a CBP that are eligible for grandfathering to notify beneficiaries in the CBA and CMS regarding their decision whether to become grandfathered suppliers.

The notification requirements we proposed will prohibit certain inappropriate practices of noncontract suppliers. These inappropriate practices include: (1) suppliers attempting to receive additional monthly rental payments from Medicare by circumventing the grandfathering requirements; and (2) suppliers not formally notifying beneficiaries before picking up the rented item from the beneficiary's home. We also proposed to require a notification process to protect beneficiaries and to ensure less confusion during the transition period prior to implementation of the CBP. The proposed requirements will help ensure that beneficiaries are contacted and informed about the grandfathering process and what choices they have concerning their choice of supplier. Moreover, the notice will help to ensure that beneficiaries do not have medically necessary DME equipment taken from them unexpectedly by a noncontract supplier.

(1) Notification of Beneficiaries by Suppliers That Choose To Become Grandfathered Suppliers

We proposed to add § 414.408(j)(5)(i) which requires a noncontract supplier that elects to become a grandfathered supplier in a CBA to provide a written notification to each Medicare beneficiary in that CBA who is currently renting a grandfathered item from that supplier. The notification must state that the supplier is willing to continue to rent the grandfathered item(s) to the beneficiary as a grandfathered supplier. The notice must identify the DME grandfathered rented items for which the supplier will be a grandfathered supplier.

To ensure that beneficiaries are sufficiently informed and prepared for competitive bidding changes that affect rented DME, we proposed in § 414.408(j)(5) to require that the notification of the beneficiary must meet the following requirements. The notification must:

- Be sent by the supplier to the beneficiary at least 30 business days before the start date of the implementation of the CBP in the CBA in which the beneficiary resides. The 30-day notice is necessary to give the beneficiary sufficient time before the start of the CBP to consider whether to continue to use their current supplier. Suppliers will be given sufficient time to meet the 30-day notification requirement.
- Identify the grandfathered items that the supplier is willing to continue to rent to the beneficiary.
- Be in writing (for example, by letter or postcard) and the supplier must maintain proof of delivery.
- State that the supplier is offering to continue to furnish certain rented DME, oxygen and oxygen equipment, and supplies that the supplier is currently furnishing to the beneficiary (that is, before the start of the CBP) and is willing to continue to provide these items to the beneficiary for the remaining rental months.
- State that the beneficiary has the choice to continue to receive a grandfathered item(s) from the grandfathered supplier or may elect to receive the item(s) from a contract supplier after the end of the last month for which a rental payment is made to the noncontract supplier.
- Provide the supplier's telephone number and instruct the beneficiaries to call the supplier with questions regarding grandfathering and to notify the supplier of his or her election.
- State that the beneficiary can obtain information about the CBP by calling 1–800–MEDICARE or accessing *http://www.medicare.gov* on the internet.

In § 414.408(j)(i)(B), we proposed that the supplier should obtain an election from the beneficiary and maintain a record of its attempts to communicate with the beneficiary to obtain the beneficiary's election regarding grandfathering. We also proposed that the supplier maintain a record of the beneficiary's choice, the date on which the choice was made, and how the beneficiary communicated his or her choice to the supplier. The 30-day notice to the beneficiary must be in writing to ensure that there is a record that the notification was made.

Comment: One commenter stated there may be difficulty contacting the beneficiary within the 30-business day requirement.

Response: We disagree. The suppliers should have an ongoing relationship with beneficiaries and be aware of how to contact them. In addition, suppliers are responsible for keeping themselves informed about the CBP and the notification requirements. When a supplier begins providing rented items to a beneficiary just prior to the start of the CBP and there are less than 30 days remaining before the start of the CBP, the supplier is required to provide the 30-day notification to the beneficiary at the time the supplier agrees to provide the items to the beneficiary. If the supplier decides not to be a grandfathered the supplier would still be required to provide the 10-day and 2-day notifications prior to picking up the equipment.

Comment: One commenter recommended that the supplier send out the initial notification letter to the beneficiary notifying them of the grandfathering option. The commenter also suggested that the beneficiary should not be required to take any additional steps if they would like to continue with their current supplier. The beneficiary would only be required to provide their current supplier with documentation if they wish to make a change to an alternate supplier.

Response: Beneficiaries are responsible for notifying their current supplier of their decision. We believe that this is the only way to ensure that the beneficiary has made an informed decision. The supplier must obtain an election from the beneficiary and document this in their records; however, this may be a verbal election.

Comment: Another commenter stated that CMS should limit the notification by noncontract supplier to a 30-day notice as to whether they will be a grandfathered supplier.

Response: We believe the notification process as outlined in the proposed rule is a necessary beneficiary protection to ensure that beneficiaries do not have medically necessary equipment taken from them unexpectedly by a noncontract supplier.

Comment: One commenter stated the notice should include information for the beneficiary on how to contact the supplier to notify them as to their decision.

Response: We agree. The proposed rule states it is a requirement to provide a 30-day written notification that should include the supplier's telephone number and instructions for the beneficiary to call the supplier to notify them of his or her election and provide the opportunity for them to ask any

questions they may have regarding grandfathering.

Comment: One commenter recommended that the two suppliers should then be required to coordinate the pickup and delivery of equipment.

Response: We agree. The proposed rule states when a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier, and the new contract supplier are responsible for making arrangements that are suitable to the beneficiary.

Comment: One commenter stated that multiple notification requirements impose a burden on suppliers who have lost competitive bids and will have little or no incentive to comply with these requirements.

Response: We disagree. The noncontract supplier has been paid for furnishing the equipment up to the first anniversary date after the start of the CBP. Therefore, they have already received compensation for this time period. In addition, the suppliers should have an ongoing relationship with the beneficiary, be aware of how to contact them, and know about any changes in their circumstances. We believe the notification process is necessary to protect the beneficiaries.

Comment: Another commenter believes that CMS has underestimated the paperwork burden requiring the beneficiary sign another document and for suppliers to track that documentation.

Response: There is no requirement for the beneficiary to sign an additional document. The supplier must obtain an election from the beneficiary; however, this may be a verbal election. We also believe suppliers should have an ongoing relationship with the beneficiaries for which they are providing items and services and billing Medicare. We do not believe this is an additional paperwork burden but rather good business practices.

After consideration of the public comments, we are finalizing this section of the proposed rule as proposed.

We proposed to add paragraphs § 414.408(j)(5)(i)(C)(*1*) through (*3*) which state if the beneficiary chooses not to continue to receive a grandfathered item(s) from the noncontract supplier, the supplier must provide the beneficiary with 2 additional notices prior to picking up its equipment. These notices are described below as the 10-Day Notification and the 2-Day Notification.

(i) 10-Day Notification

Ten business days prior to picking up the item, the supplier should have direct contact (for example, a phone call) with the beneficiary or the beneficiary's caregiver and receive acknowledgement that the beneficiary understands their equipment will be picked up and that this should occur on the first anniversary date after the start of the CBP or another date agreed to by the beneficiary. The noncontract supplier must bill and will be paid for the furnishing of the equipment up to the first anniversary date after the start of the CBP and the new supplier cannot bill for furnishing the equipment prior to this anniversary date. This requirement still applies if a date other than the anniversary date is chosen.

The beneficiary's anniversary date occurs every month on the date of the month on which the item was first delivered to the beneficiary by the current supplier. The anniversary date marks the date of every month on which a new monthly rental period begins. For example, using July 1 as the beginning date of the Medicare DMEPOS CBP:

- If a beneficiary's last anniversary date before the beginning of the CBP is June 29, the noncontract supplier must submit a claim for the rental month beginning June 29 and ending July 28. The noncontract supplier should not pick up the equipment prior to July 29. In this case, the noncontract supplier has been paid up to July 29 and therefore should pick up its equipment on July 29, and the contract supplier would deliver its equipment on July 29 and begin billing for the next month's rental as of that date.
- If a beneficiary's anniversary date is July 1, also the beginning date for the CBP, the noncontract supplier should not pick up the equipment before July 1 and should not submit a claim for the July rental period. The contract supplier should deliver the equipment to the beneficiary on July 1 and submit a claim for this month.

When a DME supplier submits a monthly bill for capped rental DME items, the date of delivery (''from'' date) on the first claim must be the ''from'' or anniversary date on all subsequent claims for the item. For example, if the first claim for a wheelchair is dated September 15, all subsequent bills must be dated for the 15th of the following months (October 15, November 15, etc.). In cases where the anniversary date falls at the end of the month (for example, January 31) and a subsequent month does not have a day with the same date (for example, February), the final date in the calendar month (for example, February 28) will be used.

Comment: One commenter stated that the burden of the coordination for the equipment pickup and replacement of an item should be placed upon the winning bidder and the losing bidder, in coordination with the beneficiary, rather than requiring the beneficiary to be in contact with both suppliers.

Response: We agree. In the proposed rule, we stated that when a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary. We believe that such arrangements need to be coordinated between the noncontract and contract supplier to ensure that the beneficiary has continued access to medically necessary equipment.

Comment: One commenter stated that the beneficiary and the new contract supplier must assume the primary responsibility for the transition. Any other allocation of responsibility between contract and noncontract supplier is impractical.

Response: We disagree. The noncontract supplier has been paid for furnishing the equipment up to the first anniversary date after the start of the CBP. Therefore, they have already received compensation for this time period. The notification process is for beneficiary protection to ensure less confusion during the transition period. Therefore, we believe the noncontract supplier must play a role in this transition.

After consideration of the public comments we received, we are finalizing this section of the proposed rule as proposed.

(ii) 2-Day Notification

Two business days prior to picking up the item, the supplier must contact the beneficiary by phone to remind the beneficiary of the date the supplier will pick up the item. This supplier should not pick up the item before the beneficiary's first anniversary date that occurs after the start of the CBP.

There may be unusual circumstances that make it difficult to contact certain beneficiaries. However, we do not expect this to occur often because these suppliers have been submitting monthly rental claims for providing services to these beneficiaries. Therefore, the supplier should have an ongoing relationship with the beneficiary and be aware of how to contact them and any changes in their circumstances. However, under no circumstance should a supplier pick up a rented item prior to the supplier's receiving acknowledgement from the beneficiary that they are aware of the date on which the supplier is picking up the item and that arrangements have been made to have the item replaced on that date by a contract supplier. The pickup of the

noncontract supplier's equipment and the delivery of the new contract supplier's equipment should occur on the same date. The pick up by the noncontract supplier and the delivery by the contract supplier should occur on the first rental anniversary date of the equipment that occurs after the start of the CBP. When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary. This provides some latitude, for the pickup and the delivery date but not in terms of billing. The new equipment cannot be billed for until the anniversary date and the old equipment cannot be taken from the beneficiary before the anniversary date.

Comment: One commenter stated that if a supplier decides it does not want to grandfather a product category, it should be sufficient if the supplier provides notice one time in writing and follows up by phone as the deadline for transitioning approaches.

Response: We agree. The initial 30-day notification must be in writing to ensure there is a record that the notification was made. The supplier must maintain a record of its attempts to communicate with the beneficiary to obtain the beneficiary's election regarding grandfathering. The supplier must maintain a record of the beneficiary's choice, the date on which the choice was made, and how the beneficiary communicated his or her choice to the supplier. The 10 and 2-day notices can be done by phone. We proposed the 10 and 2-day notification process as a safeguard to protect Medicare beneficiaries and ensure that the beneficiary has continued access to medically necessary equipment. We do not believe this process is too burdensome because these suppliers have been submitting monthly rental claims for providing services to these beneficiaries and this notice can be satisfied by a phone call to the beneficiary.

After consideration of the public comments we received, we are not making any changes to this section of the proposed rule and finalizing it as proposed.

c. Notification to CMS for Suppliers That Choose To Become Grandfathered

We proposed to add § 414.408(j)(5)(ii) to state that suppliers that have chosen to become grandfathered suppliers must also notify CMS of their decision at least 30 business days before the start of the CBP. We believe that 30 business days is a reasonable period to allow CMS to compile a list of grandfathered suppliers and to answer questions about the availability of these suppliers. Unless the supplier notifies CMS consistent with this subsection, the supplier will not be considered a grandfathered supplier. Having a list of grandfathered suppliers is important to assist CMS in administering the grandfathering process. The list will be used to answer questions from beneficiaries concerning which suppliers have chosen the grandfathering option. The notification requirement will also help us to ensure that suppliers are not offering the grandfathering option to only a select number of beneficiaries. Also, having a list of suppliers that have chosen to be grandfathered suppliers will assist us in reviewing whether only noncontract suppliers that have elected to be grandfathered suppliers have received Medicare payment for rented competitive bid items in a CBA.

The notice that a noncontract supplier must provide to CMS if it elects to become a grandfathered supplier must meet the following requirements:

- State that the supplier agrees to continue to furnish certain rented DME, oxygen and oxygen equipment that it is currently furnishing to beneficiaries (that is, before the start of the CBP) in a CBA and will continue to provide these grandfathered items to these beneficiaries for the remaining months of the rental period.
- Include all of the following: Name and address of the supplier; 6-digit NSC number of the supplier; and product category(s) by CBA for which the supplier is willing to be a grandfathered supplier.
- Suppliers with multiple locations must submit one notification for the company rather than for each individual location.
- State that the supplier agrees to meet all the terms and conditions applicable to grandfathered suppliers.
- Be provided by the supplier to CMS in writing at least 30 business days before the start date of the implementation of a CBP.

d. Notifications of Beneficiaries by Suppliers That Choose Not To Become Grandfathered Suppliers

We propose to clarify under § 414.408(j)(6) that a noncontract supplier that elects not to become a grandfathered supplier is required to pick up the item it is currently renting to the beneficiary from the beneficiary's home after proper notice to the beneficiary. A noncontract supplier that decides not to become a grandfathered supplier does not have the option of leaving its equipment in the beneficiary's home. The noncontract supplier is responsible for picking up the item from the beneficiary.

Proper notification by a supplier who chooses not to become a grandfathered supplier must include a 30-day, a 10-day, and a 2-day notice of its decision not to be a grandfathered supplier. These notifications must meet all of the requirements listed above for the 30-day, 10-day and 2-day notices that must be sent by suppliers who decide to be grandfathered suppliers, except for the following differences for the 30-day notice.

- The 30-day notice must indicate the items for which the supplier has decided not to become a grandfathered supplier and indicate the date upon which the equipment will be picked up.
- It must state that the supplier will only continue to rent these competitively bid item(s) up to the beneficiary's first anniversary date, as defined in § 414.408(j)(5), that occurs after the start of the Medicare DMEPOS CBP.
- It must also state that the beneficiary must select a contract supplier for Medicare to continue to pay for these items.

It must state that the beneficiary can obtain information about the CBP by calling 1–800–MEDICARE or accessing *http://www.medicare.gov* on the internet.

- It must also refer him or her to the supplier locator tool on *http://www.medicare.gov*.

The supplier must also provide the beneficiary with the 10-day and the 2-day notices prior to picking up their equipment.

When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary. This provides some latitude, but the new equipment may not be billed by the contract supplier until the first anniversary date following the start of the CBP. Also, the old equipment may not be taken from the beneficiary before proper arrangements are made and the date of service cannot occur before the anniversary date.

As discussed above, under no circumstance should a supplier pick up the rented item prior to the supplier making an arrangement with the new contract supplier for the delivery of the new equipment at a time suitable to meet the beneficiary's medical needs. The noncontract supplier has been furnishing services to the beneficiary and receiving payments from the program. To ensure that the beneficiary has continued access to medically necessary equipment, the noncontract

supplier is expected to assist the beneficiary in locating a contract supplier. The noncontract supplier should communicate with the beneficiary the urgency of arranging to have the new equipment delivered as soon as possible.

e. Other Comments

Comment: Several commenters stated that the current accreditation and surety bond requirements were too burdensome.

Response: All comments concerning accreditation and surety bond requirements are considered beyond the scope of this rulemaking.

We are finalizing the provisions concerning grandfathering as proposed in the CY 2010 PFS proposed rule (74 FR 33644).

P. Five-Year Refinement of Relative Value Units

1. Background

Section 1848(c)(2)(C)(i) of the statute states that the Secretary shall determine a number of work RVUs for the service based on the relative resources incorporating physician time and intensity required in furnishing the service. Section 1848(c)(2)(B)(i) of the Act requires that we review all RVUs no less than every 5 years.

We initiated the first Five-Year Review of work RVUs in 1994 and refinements went into effect beginning in 1997 (59 FR 63410 and 61 FR 59490). The scope of the Five-Year Review was limited to work values, since at that time, the statute required that PE and malpractice RVUs be calculated based on 1991 allowed charges and PE and malpractice expense shares for the specialties performing the services.

The second Five-Year Review of physician work RVUs began in 1999 and refinements went into effect beginning in CY 2002 (64 FR 59380 and 66 FR 55246). The third Five-Year Review of the physician work RVUs began in CY 2004 with the resulting changes being effective beginning in 2007 (69 FR 66236 and 71 FR 69624).

While the statute requires the Secretary to review the relative values for services no less than every 5 years, the work RVUs for many services, have never been specifically reviewed since the inception of the PFS. Since we approach our review with the underlying assumption that services are appropriately valued, the focus of the Five-Year Reviews has been on potentially misvalued services that are identified by us or commenters.

2. Codes Reviewed Outside the Usual Five-Year Review Process

Although it was our practice for many years to wait for the next Five-Year Review to review and revise any potentially misvalued services, we remained concerned that it was inappropriate to wait 5 years (or until the next Five-Year Review of work RVUs) when we had some evidence that certain services were not valued correctly. MedPAC, the Congress, and other stakeholders have expressed similar concerns.

Subsequent to the completion of the third Five-Year Review, in collaboration with the AMA RUC, based on the additional concern that some services had not been reviewed since the inception of the PFS we have undertaken to review certain potentially misvalued codes. This effort is discussed elsewhere in this final rule with comment period (see section II.F.). The fourth Five–year Review will be conducted independently of the review of codes under the potentially misvalued code initiative.

3. Fourth Five-Year Review of Work RVUs

We are initiating the fourth Five-Year Review of work RVUs with the resulting changes being effective beginning in 2012. As with the previous Five-Year Reviews, we are soliciting comments only on services for which the currently assigned work RVUs may be inappropriate. To the extent that there are changes in physician time or in the number or level of post procedure visits as a result of the Five-Year Review of work, the PE inputs, and we could be impacted and we would them accordingly.

Under the Five-Year Review process, we solicit comments from the public on codes that are potentially misvalued. We then review the public comments and forward codes identified in those comments, as well as codes that we have identified as potentially misvalued, to the AMA RUC. The AMA RUC then follows a process, similar to that used for new CPT codes (see description below). The AMA RUC:

- Surveys its members to assess their level of interest in reviewing relative values for certain services (and to identify services for which the code descriptors may no longer be appropriate);
- Develops survey instruments for the specialty societies to use to assess the work or level of effort involved with the service;
- Asks specialty committees to conduct the surveys, review the results and prepare their recommendations for the AMA RUC; and
- Reviews the specialty committee recommendations and may either adopt them, refer them back to the specialty society or modify them prior to submitting its recommendations to CMS.

We then review the AMA RUC recommendations, decide whether we agree or disagree, and propose to accept or reject/revise the AMA RUC recommendations. Our responses to the AMA RUC recommendations are presented, and any changes in valuations are established through notice and comment rulemaking.

Consistent with the format for the previous Five-Year Reviews, in addition to the codes submitted by the commenters, we will also identify codes and submit them to the AMA RUC. Our focus will be on codes (especially high-volume codes across specialties) that:

- Are valued as being performed in the inpatient setting, but that are now predominantly performed on an outpatient basis, and
- Were not previously reviewed by the AMA RUC, (for example, Harvard-based codes).

In prior years, we solicited comments on codes for which there is a rank order anomaly within the family of codes, and accepted the possible existence of a rank order anomaly as a primary reason for specialty societies to submit codes for review. An anomalous relationship may exist between the code being valued and other codes. For example, code A describes a service that requires more work than codes B, C, and D, but code A is valued lower. For the fourth Five-Year Review of work RVUs, we will no longer consider the existence of a possible rank order anomaly to be the primary basis for undertaking the review of a code. However, rank order anomalies will continue to be used as a way to screen for potential problem areas.

In addition, when we submit codes to the RUC for review, we note that in order to maintain relativity, we may decide to submit the entire family of codes (including the base code) for review. The base code is the most important code to review because it is the basis for the valuation of other codes within the family and allows for all related codes to be reviewed at the same time. We believe that reviewing the entire family of codes can assist in ensuring relativity between services and consistent valuation of services.

We also note that codes that have been reviewed/revised under the potentially misvalued code initiative may also be considered for review under

the Five-Year Review of work RVUs. We believe this will allow for the most systematic review possible to ensure the appropriateness of values under the PFS.

The AMA RUC has developed detailed ''Compelling Evidence Standards'' which are used by the RUC as part of its process to determine if a recommendation to change the work RVU is warranted for a given code. We are including these standards in section II.P.4. of this final rule with comment period solely for informational purposes so that commenters are aware of the kind of information that has been used in the past to make a successful argument to the RUC for changing work RVUs.

We typically publish a proposed notice for the Five-Year Review separate from the annual notice of proposed rulemaking that is published for the PFS. Publishing the Five-Year Review notice separate from the annual PFS rule allows time for the potential establishment of refinement panels to address comments received on proposed work RVU changes resulting from the Five-Year Review.

The fourth Five-Year Review of Work RVUs will be addressed in a proposed notice that we intend to publish in the spring of 2011. In that proposed notice, we will discuss: the codes considered for review under this fourth Five-Year Review; the AMA RUC recommended work RVUs; and our proposed valuation of the services, including the rationale for the work valuation. We will solicit comments on our proposed valuation of the codes. We will then review and analyze the comments received in response to the proposed notice and publish our decisions as part of the CY 2012 PFS final rule with comment period. (As previously mentioned, in past years we have addressed comments on the proposed notice through the use of refinement panels, similar to those used to address comments received on interim values for new or revised codes.) The changes would be effective January 1, 2012.

In the last Five-Year Review of work RVUs, some specialty societies used methods other than the AMA RUC-developed survey instrument to arrive at recommended work RVUs. These methods included reliance on other data sources (for example, Department of Veteran Affairs (VA) National Surgical Quality Improvement Program (NSQIP) and the Society for Thoracic Surgeons (STS) databases).

- The NSQIP was initiated by the VA for quality improvement purposes in 1991 with 128 VA medical centers. It currently includes a large volume of surgical procedures from non-VA medical centers as well. The total number of cases for VA and non-VA medical centers is greater than one million. The NSQIP database contains pre-, intra-, and post-operative data, including intra-service times and length of stay data.
- The STS National database is a voluntary reporting system for the collection of outcomes data related to cardiothoracic surgical services. This database currently contains over two million patient records collected from more than 450 practices (from 1995 through 2004). Over 70 percent of the hospitals currently performing heart surgeries in the U.S. reportedly participate in this database.

As discussed earlier in this section, specialty societies usually rely on the AMA RUC survey process to arrive at work values for their services, often referencing the median work value (50th percentile) resulting from the survey as a recommendation for a proposed work RVU. However, for the last Five-Year Review, a few specialty societies used other data sources, such as those mentioned above, to establish recommended work values. We are concerned that reliance solely on these other data sources could result in an inconsistent assignment of work RVUs, eroding the relativity of the PFS.

We would like to emphasize that the most common approach used by the AMA RUC for valuation of the work of a service is the building block approach. In constructing the building blocks, a service is divided into pre-, intra-, and post-service components. For a surgical procedure, the pre-service component consists of all services furnished before the physician makes the skin incision (for example, pre-operative evaluation and scrubbing); the intra-service component consists of the ''skin-to-skin'' time (that is the operative time between surgical opening and closing); and the post-service component includes immediate post-surgery services and subsequent hospital and office visits. Each component (or building block) is then assigned work RVUs. Pre-service and intra-service work RVUs are based on time and the intensity of the activities. Post-service work is based on the specified E/M service for each post-operative visit. These three component work values are then summed to compute ''building-block'' work RVUs.

For purposes of the fourth Five-Year Review of work RVUs and in order to gain a better understanding of the distribution of data from surveys and other data sources submitted in support of work RVU refinements, we will require that the minimum/maximum values, the 5th, 25th, 50th (median), 75th, and 95th percentiles be reported. In addition, we will require reporting of the geometric mean. This is similar to information currently reported for the specialty surveys, with some additional percentiles and the geometric mean being included. However if the AMA RUC recommendation does not include the information discussed above we may reject the recommendation.

To the extent the PQRI databases may include information similar to that previously described in the physician surveys, these databases might serve as an additional source for establishing or validating work RVUs.

4. RUC Compelling Evidence Standards

The AMA RUC operates with the initial presumption that the current values assigned to the codes under review are correct. This presumption can be challenged by a society or other organization presenting a compelling argument that the existing values are no longer rational or appropriate for the codes in question. The justification for a change must be substantial and meet the RUC's compelling evidence standards.

The argument in support of a change in work RVUs must be provided in a comment letter to us, and then later to the AMA RUC in writing on the Summary of Recommendation form. The following guidelines may be used to develop a ''compelling argument'' that the published relative value units assigned for a service are inappropriate:

- Documentation in the peer reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:
  - ++ Technique.
  - ++ Knowledge and technology.
  - ++ Patient population.
  - ++ Site-of-service.
  - ++ Length of hospital stay.
  - ++ Physician time.
- An anomalous relationship between the code being proposed for review and other codes. For example, if code A describes a service that requires more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being consideredand the codes to which it is compared. These reference services may be both inter- and intra-specialty. (**Note:** The AMA RUC may wish to continue to use this as part of its method for determination of compelling evidence. However, if it is

not used according to the parameters we have discussed earlier in this section we may reject the AMA RUC recommendation.)

• Evidence that technology has changed physician work, that is, diffusion of technology.

• Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.

• Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:

++ A misleading vignette, survey, or flawed crosswalk assumptions in a previous evaluation;

++ A flawed mechanism or methodology used in the previous valuation, for example, evidence that no pediatricians were consulted in assigning pediatric values; and

++ A previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.

5. Five-Year Review of Other PFS Components

a. Malpractice RVUs

From 1992 to 1999, malpractice RVUs were charge-based, using weighted specialty-specific malpractice expense percentages and 1991 average allowed charges. Malpractice RVUs for new codes after 1991 were extrapolated from similar existing codes or as a percentage of the corresponding work RVU. Section 4505(f) of the BBA required us to implement resource-based malpractice RVUs for services furnished beginning in 2000. Initial implementation of resource-based malpractice RVUs occurred in 2000. The statute also requires that we review, and if necessary adjust, RVUs no less often than every 5 years. The first review and update of resource based malpractice RVUs was addressed in the CY 2005 PFS final rule (69 FR 66263). Minor modifications to the methodology were addressed in the CY 2006 PFS final rule (70 FR 70153). In this rule, we are implementing the second review and update of malpractice RVUs (see section II.C. of this final rule with comment period).

b. Practice Expense RVUs

The resource-based PE RVUs were effective January 1, 1999. To assist in the refinement of the direct PE inputs (developed by the specialty-specific Clinical Practice Expense Panels conducted in the late 1990s), the AMA RUC created the Practice Expense Advisory Committee (PEAC) in CY 1999. The PEAC refined the PE inputs for nearly all of the CPT codes in the PFS by the time it sunsetted 5 years later in March 2004. (The remainder of the codes, approximately 200, were refined at the September 2004 and February 2005 AMA RUC meetings.) These PEAC (and subsequent AMA RUC) refinements of the PE inputs were provided as recommendations to CMS.

A comprehensive review of PE was undertaken prior to the 4-year transition period for the PE methodology from the top-down to the bottom-up methodology which will be complete in 2010. In this final rule with comment period we are incorporating new Physician Practice Information Survey (PPIS) data. (These data are used to update the specialty-specific PE/HR data used to develop PE RVUs.)

The next Five-Year Review of PE RVUs will be addressed in CY 2014 and we are soliciting comments on approaches to take for this next Five-Year Review of PE RVUs. However, to the extent that there are changes in physician time or in the number or level of post procedure visits as a result of the fourth Five-Year Review of work, there will be a potential impact on the practice expense inputs, and we will revise the inputs accordingly.

In the interim, we will continue with our efforts as part of the misvalued code initiative to develop a process to ensure that prices for certain high cost supplies that are used to determine PE RVUs are accurate and reflect current information.

Q. Other Issues: 2010 Therapy Caps

Section 1833(g) of the Act applies an annual, per beneficiary combined cap on expenses incurred for outpatient physical therapy and speech-language pathology services under Medicare Part B. A similar separate cap for outpatient occupational therapy services under Medicare Part B also applies. (The caps do not apply to expenses incurred for therapy services furnished in an outpatient hospital setting.) The caps were in effect during 1999, from September 1, 2003 through December 7, 2003 and beginning January 1, 2006. Also beginning January 1, 2006, the Deficit Reduction Act (Pub. L. 109–171) (DRA) provided for an exception process to the therapy cap until December 31, 2006. Subsequent legislation (MIEA–TRHCA and the MMSEA) extended the exception process for therapy caps until December 31, 2007 and June 30, 2008, respectively. Section 141 of the MIPPA extended the exception process through December 31, 2009. Several therapy associations have requested that we announce the amount of the therapy cap for CY 2010 in the PFS final rule.

The annual, per beneficiary therapy cap for CY 2010 is computed by multiplying the cap amount for CY 2009, which is $1840, by the Medicare Economic Index, which is 1.2 percent, and rounding to the nearest $10. Therefore, each cap for CY 2010 will be $1860. The agency's authority to provide for exceptions to therapy caps will expire on December 31, 2009, unless the Congress acts to extend it. If the current exception process expires, the only exceptions to therapy caps will be for services billed by the outpatient hospitals.

III. Refinement of Relative Value Units for Calendar Year 2010 and Response to Public Comments on Interim Relative Value Units for 2009

A. Summary of Issues Discussed Related to the Adjustment of Relative Value Units

Sections III.B. and III.C. of this final rule with comment describe the methodology used to review the comments received on the RVUs for physician work and the process used to establish RVUs for new and revised CPT codes. Changes to the RVUs and billing status codes reflected in Addendum B are effective for services furnished beginning January 1, 2010.

B. Process for Establishing Work Relative Value Units for the Physician Fee Schedule

The CY 2009 PFS final rule with comment period (73 FR 69726) contained the work RVUs for Medicare payment for existing procedure codes under the PFS and interim RVUs for new and revised codes beginning January 1, 2009. We considered the RVUs for the interim codes to be subject to public comment under the annual refinement process. In this section, we address comments on the interim work RVUs published in the CY 2009 PFS final rule with comment period, and our establishment of the work RVUs for new and revised codes for the CY 2010 PFS.

C. Work Relative Value Unit Refinements of Interim Relative Value Units

1. Methodology (Includes Table titled ''Work Relative Value Unit Refinements of the 2009 Interim and Related Relative Value Units'')

Although the RVUs in the CY 2009 PFS final rule with comment period were used to calculate 2009 payment amounts, we considered the RVUs for the new or revised codes to be interim.

We accepted comments for a period of 60 days. We received substantive comments on approximately 12 CPT codes with interim work RVUs.

To evaluate these comments we used a process similar to the process used since 1997. (See the October 31, 1997 final rule (62 FR 59084) for the discussion of refinement of CPT codes with interim work RVUs.) We convened a multispecialty panel of physicians to assist us in the review of the comments. We invited representatives from the organizations from which we received substantive comments to attend a panel for discussion of the code on which they had commented. The panel was moderated by our medical staff, and consisted of the following voting members:

- One or two clinicians representing the commenting organization.
- Two primary care clinicians nominated by the American Academy of Family Physicians and the American College of Physicians.
- Four carrier medical directors.
- Clinicians with practices in related specialties who were expected to have knowledge of the services under review.

The panel discussed the work involved in the procedure under review in comparison to the work associated with other services under the PFS. We assembled a set of 300 reference services and asked the panel members to compare the clinical aspects of the work of the service a commenter believed was incorrectly valued to one or more of the reference services. In compiling the set, we attempted to include: (1) Services that are commonly performed whose work RVUs are not controversial; (2) services that span the entire spectrum from the easiest to the most difficult; and (3) at least three services performed by each of the major specialties so that each specialty would be represented. The intent of the panel process was to capture each participant's independent judgment based on the discussion and his or her clinical experience. Following the discussion, each participant rated the work for the procedure. Ratings were individual and confidential, and there was no attempt to achieve consensus among the panel members.

We then analyzed the ratings based on a presumption that the interim RVUs were correct. To overcome this presumption, the inaccuracy of the interim RVUs had to be apparent to the broad range of physicians participating in each panel.

Ratings of work were analyzed for consistency among the groups represented on each panel. In addition, we used statistical tests to determine whether there was enough agreement among the groups of the panel and whether the agreed-upon RVUs were significantly different from the interim RVUs published in Addendum C of the final rule. We did not modify the RVUs unless there was a clear indication for a change. If there was agreement across groups for change, but the groups did not agree on what the new RVUs should be, we eliminated the outlier group and looked for agreement among the remaining groups as the basis for new RVUs. We used the same methodology in analyzing the ratings that we first used in the refinement process for the 1993 PFS. The statistical tests were described in detail in the November 25, 1992 final rule (57 FR 55938).

Our decision to convene multispecialty panels of physicians and to apply the statistical tests described above was based on our need to balance the interests of those who commented on the work RVUs against the redistributive effects that would occur in other specialties.

The following table lists those interim codes reviewed under the refinement panel process described in this section. This table includes the following information:

- CPT Code. This is the CPT code for a service.
- Description. This is an abbreviated version of the narrative description of the code.
- 2009 Work RVU. The work RVUs that appeared in the November 2008 rule are shown for each reviewed code.
- Requested Work RVU. This column identifies the work RVUs requested by commenters.
- 2010 Work RVU. This column contains the final RVUs for physician work.

2009 Interim Work Relative Value Units For Codes Reviewed Under the Refinement Panel Process

CPT Code[1]	Mod	Descriptor	2009 Work RVU	Requested Work RVU	2010 Work RVU[2]
17106		Destruction Of Skin Lesions	3.61	4.55	3.69
17107		Destruction Of Skin Lesions	4.68	9.18	4.79
17108		Destruction Of Skin Lesions	6.37	13.52	7.49
61796		Srs, Cranial Lesion Simple	10.79	15.75	13.93
61798		Srs, Cranial Lesion Complex	10.79	19.75	19.85
63620		Srs, Spinal Lesion	10.79	18.00	15.60
93282	26	Icd Device Prog Eval, 1 Sngl	0.85	0.91	0.85
93283	26	Icd Device Progr Eval, Dual	1.05	1.20	1.15
93289	26	Icd Device Interrogate	0.78	1.03	0.92
93295		Icd Device Interrogat Remote	1.17	1.28	1.29
97802		Medical Nutrition, Indiv, In	0.53	0.75/0.65	0.53
97803		Med Nutrition, Indiv, Subseq	0.45	0.55/0.65	0.45

[1] All CPT codes and descriptions copyright 2009 American Medical Association. All rights reserved and applicable FARS/DFARS clauses apply.

[2] Work RVU values included in the summaries below may differ from the 2010 work RVU noted in this table due to work increases in 10 and 90 day global codes as a result of the elimination of the consultation codes.

D. Interim 2009 Codes

1. Destruction of Skin Lesions Codes

CPT codes 17106, *Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm, 17107, Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 to 50.0 sq cm,* and 17108, *Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq cm* were identified by the AMA RUC's Five-Year Review Identification Workgroup through the high intra-service work per unit of time (IWPUT) screen. The AMA RUC recommended 3.61 work RVUs for CPT code 17106, 4.68 work RVUs for

CPT code 17107, and 6.37 work RVUs for CPT code 17108, which we accepted in the CY 2009 PFS final rule with comment (73 FR 69884).

Comment: Commenters disagreed with the AMA RUC-recommended work values for these services, which we had accepted. The commenters expressed concerns about the AMA RUC's use of IWPUT to not only identify potentially misvalued services but also to revalue them. Commenters were also concerned that a ranking system (that is, IWPUT) not formally recognized by CMS had been used inappropriately to identify and value these services. Many commenters encouraged CMS to conduct a Refinement Panel Review of the valuation of these codes.

Response: Based on these concerns, we referred these codes to the Multi-Specialty Validation Panel for review. As a result of the statistical analysis of the 2009 Multi-Specialty Validation Panel ratings, we have assigned 3.61 work RVUs to CPT code 17106, 4.68 work RVUs to CPT code 17107, and 7.35 work RVUs to CPT code 17108.

2. Hemorrhoidectomy Code

For CPT code 46930, *Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency),* the AMA RUC recommended 1.56 work RVUs and a global period assignment of 090 (major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount), which we accepted in the CY 2009 PFS final rule with comment (73 FR 69892).

Comment: We received comments from independent providers, one manufacturer, and specialty societies representing gastroenterologists who disagreed with the 90-day global period assignment and requested that we assign a 10-day (minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount) global period instead. The commenters believe this procedure is a minor procedure and a 10-day global period assignment would be appropriate. The commenters also believe that the work RVUs assigned to this procedure are more in line with a 10-day global period. We did not receive any comments from the colon and rectal surgeons and general surgeons who participated in the survey of this code and predominately perform this procedure.

Response: Prior to the creation of CPT code 46930, this procedure was performed using deleted CPT code 46934, *Destruction of hemorrhoids, any method; internal* which was assigned a 90-day global period. We believe the valuation and assignment of a 90-day global period is appropriate for this procedure. The post-operative care and potential clinical problems remain the same despite having a new technology to address this clinical condition. We will plan to review the clinical experience with this technology in the future to learn how patients fared who underwent destruction of hemorrhoids with this new technology. In the meantime, we will maintain a 90-day global period for this procedure.

3. Stereotactic Radiosurgery Codes

For CPT codes 61796, *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion,* 61797, *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple,* and 63620, *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion* the AMA RUC recommended 15.50 work RVUs for CPT code 61796, 19.75 work RVUs for CPT code 61798, and 15.50 work RVUs for CPT code 63620. We disagreed with the AMA RUC recommendations and assigned 10.79 work RVUs to all three of these codes in the CY 2009 PFS final rule with comment (73 FR 69892). We believed the specialty societies and the AMA RUC, in general, used open surgical codes as comparators during the AMA RUC process instead of a more equivalent stereotactic radiation treatment code.

Comment: The commenters disagreed with the interim work RVUs assigned by CMS and urged CMS to accept the AMA RUC-recommended values for these codes. The commenters believed CMS erred in basing the interim values on the work RVUs of two radiation oncology services instead of surgical codes. The commenters expressed that sterotactic radiosurgey is much more intense than radiation therapy. Commenters were also confused as to why CMS valued CPT codes 61796, 61798, and 63620 identically since CPT code 61796 describes treatment of a ''simple'' cranial lesion and CPT code 61798 describes treatment of a ''complex'' cranial lesion. The commenters believed the work required to treat complex lesions is much greater than the work required to treat simple lesions. Based on these concerns, we referred these codes to the Multi-Specialty Validation Panel for review.

Response: As a result of the statistical analysis of the 2009 Multi-Specialty Validation Panel ratings, we have assigned 13.83 work RVUs to CPT code 61796, 19.75 work RVUs to CPT code 61798, and 15.50 work RVUs to CPT code 63620.

4. Cardiac Monitoring Codes

For CPT codes 92382, *Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead implantable cardioverter-defibrillator system,* 93283, *Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead implantable cardioverter-defibrillator system,* 92389, *Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead implantable cardioverter-defibrillator system, including analysis of heart rhythm derived data elements,* and 93295, *Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable cardioverter-defibrillator system with interim physician analysis, review(s) and report(s),* the AMA RUC recommended 0.85 work RVUs for CPT code 93282, 1.18 work RVUs for CPT code 93283, 0.92 work RVUs for CPT code 93289, and 1.38 work RVUs for CPT code 93295. We agreed with the AMA RUC-recommended value for CPT code 93282, but disagreed with the AMA RUC-recommended value for CPT codes 93283, 93289, 93295 in the CY 2009 PFS final rule with comment (73 FR 69892). We questioned the recommended values for the increments between some codes within families and across families of pacemakers, implantable cardioverter defibrillators (ICDs), implantable loop recorders, and implantable cardiovascular monitoring systems and the methodology used to determine the AMA RUC recommended values. The AMA RUC primarily used a comparison methodology to determine the value of the pacemaker codes and the surveyed 25th percentile to determine the value of the implantable ICD codes. Even though different methodologies were utilized to develop the recommended values, we did not understand why the increments between various levels of the pacemaker programming codes were not also the appropriate increment between the various levels of ICD programming codes. Therefore, we did not accept the AMA RUC recommendations for CPT

codes 93283, 93289, and 93295. Instead, we established work RVUs that maintained the same incremental difference between levels of programming codes. We assigned 1.05 work RVUs to CPT code 93283, 0.78 work RVUs to CPT code 93289, and 1.17 work RVUs to CPT code 93295.

Comment: Commenters were disappointed that CMS did not accept the AMA RUC-recommended work RVUs and disagreed with CMS' assumption that there is a constant increment of work added to the programming evaluation of an ICD as it progresses from a single lead to dual lead device and from a dual lead to a multiple lead device. Commenters also disagreed with the comparison codes we used to value these codes. Although we agreed with the AMA RUC-recommended value for CPT code 93282, one commenter requested that we increase the work RVU. Based on these concerns, we referred these codes to the Multi-Specialty Validation Panel for review.

Response: As a result of the statistical analysis of the 2009 Multi-Specialty Validation Panel ratings, we have assigned 0.85 work RVUs to CPT code 93282, 1.15 work RVUs to CPT code 93283, 0.92 work RVUs to CPT code 93289, and 1.29 work RVUs to CPT code 93295.

6. Medical Nutrition Therapy

For CPT codes 97802, *Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes* and 97803, *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes,* the AMA RUC-recommended 0.53 work RVUs for CPT code 97802 and 0.45 work RVUs for CPT Code 97803, to which we agreed in the CY 2009 PFS final rule with comment (73 FR 69890).

Comment: We received a comment from a provider who disagreed with CMS' acceptance of the AMA RUC-recommended work RVUs. The commenter believed the values were flawed as a result of a methodological error dating back to the 2000 Health Care Professional Advisory Committee (HCPAC) recommendations. The commenter requested that we establish accurate work RVUs (an RVU value of 0.65 for both codes) or that we ask the AMA RUC to revisit its recommendation. Based on these concerns, we referred these codes to the Multi-Specialty Validation Panel for review.

Response: As a result of the statistical analysis of the 2009 Multi-Specialty Validation Panel ratings, we have assigned 0.53 work RVUs to CPT code 97802 and 0.45 work RVUs to CPT code 97803.

In the CY 2009 PFS final rule with comment period we also responded to the RUC recommendations on the PE inputs for new and revised CPT codes for CY 2009. In addition to the PE comments discussed in section II.B.2. of this final rule with comment period we received the following comments concerning PE inputs.

- CPT Codes 46606, 46608, 46610, 46612, and 46930: CPT code 46930, *Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency),* was a new CPT code for 2009. In the CY 2009 PFS final rule (73 FR 69897), we asked for comments on whether a light guide is typical for this code and any of the other existing codes. Specifically, we did not accept the AMA RUC-recommended sheath to cover the light guide that the specialty proposed to add to the PE database for this service and 4 other procedures as we do not believe it to be typically used in furnishing these services. Because the light guide was not a component of the infrared coagulator item at the time we re-priced our entire equipment file for CY 2005, and because this same equipment item is used for 4 other endoscopy procedures, including CPT codes 46606, 46608, 46610, and 46612, we asked commenters to provide us with information and documentation as to whether the light guide is typical to any of these 5 procedures. Additionally, we invited comments about the typical use of the sheath in relationship to the light guide. In the interim, we assigned the new equipment price including the light guide to the new CPT code 46930 as well as the four other procedures that employ this infrared coagulator for CY 2009.

Comment: We received one comment stating that the sheath for the light guide is required for CPT code 46930 given the potential for contamination of the light guide if a sheath is not used, as well as the difficulty of cleaning the light guide if it is contaminated. Commenters also stated that the infrared equipment (EQ136) used with the sheath is not required for CPT codes 46606, *Anoscopy; with biopsy, single or multiple,* 46608, *Anoscopy; with removal of foreign body,* 46610, *Anoscopy; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery,* and 46612, *Anoscopy; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique,* as these procedures are typically performed using electrocautery for which PE inputs are already associated with these codes.

Response: We thank the commenters for their input. We are leaving the PE inputs as is while we conduct additional research on what is typical in furnishing these procedures.

- CPT Codes 93306, 93307, 93320, 93325, and 93351: In the CY 2009 PFS final rule (73 FR 69898), we discussed the AMA RUC PE recommendations for CPT codes 93306, *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography,* and 93351, *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision.*

For CPT code 93306, we stated that the AMA RUC did not recommend any changes to the PE direct inputs for the related echocardiography codes 93307, *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography,* 93320, *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete,* and 93325, *Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography).* We asked the AMA RUC to review the PE inputs for CPT codes 93307, 93320, and 93325 to ensure that they are consistent with the recommended direct inputs for CPT code 93306.

For CPT code 93351, we stated that the AMA RUC-recommended PE inputs included three new equipment items. These items included an ultrasound machine, an echocardiography exam table, and a dual image viewing and reporting system. We did not accept the recommended ultrasound machine valued at $325,000 but used a model in a similar procedure priced at $248,000 in the PE database. We also did not accept the echocardiography exam table ($11,095) because we did not believe it was a typical equipment item found in the physician's office. Instead, we assigned the PE input typical for a similar service—a $1,915 stretcher. We

included the ''dual'' echocardiography image viewing and reporting system but we accepted the base unit price of $85,000 in place of the $173,000 price provided by the specialty.

We asked commenters to provide us with documentation as to the type and cost of equipment that is used in furnishing the procedure in the physician office along with a rationale for suggested changes from the existing inputs. We also asked commenters to provide us with the typical scenario as to whether one, two, or three ultrasound units will be connected to the third equipment item, the ''dual'' echocardiography image viewing, and reporting system. We asked for information as to the amount of time that the dual image management system is in use for this procedure.

Comment: Several commenters requested that CMS revise the PE inputs associated with CPT codes 93306 and 93351. Specifically, for CPT code 93306, commenters stated that there are increased equipment costs, that an echocardiography room should be included, and that the equipment times should be revised from 42 minutes to 63 minutes to reflect their intra-service use by the sonographer. For 93351, commenters requested that a higher priced echocardiography machine, an echocardiography table, and a cardiac ultrasound room be added to the equipment list. Commenters also requested that we update the price of the dual echocardiography image viewing and reporting system to reflect the more common purchase of this equipment with additional features compared to the base model.

Response: For CPT code 93306, we do not agree that use of an echocardiography room is typical, nor do we believe higher equipment costs are justified at this time. However, we do agree with commenters that equipment times should be increased to 63 minutes from 42 minutes to accurately reflect the use of this equipment during the procedure and have adjusted the PE database to reflect this. For CPT code 93351, the AMA RUC did not recommend these higher cost PE inputs and we agreed with them. We believe we valued the PE inputs for these CPT codes appropriately in the CY 2009 final rule. Therefore, we will assign the PE inputs from the PE database for similar services—$248,000 for the ultrasound machine and $1,915 for the stretcher—to these codes. We will also continue to use the accepted base unit price of $85,000 for the ''dual'' echocardiography image viewing and reporting system. In addition, we were advised by the AMA RUC that only one ultrasound unit is typically connected to this management system, which is used for 7 minutes during the procedure. We agree with the AMA RUC's advice.

- CPT Codes 93293 and 93296: In the CY 2009 final rule (73 FR 69897), we discussed CPT codes 93293, *Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with physician analysis, review and report(s), up to 90 days,* and 93296, *Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results* (73 FR 69897). The AMA RUC recommended that a ''pacemaker interrogation system'' be used for the two CPT codes 93293 and 93296. However, the PE database does not contain an equipment item with this description. Because we noted a 100 percent crosswalk from existing CPT code 93733 that utilizes the pacemaker follow-up system to the new CPT code 93293, we assigned, on an interim basis, the pacemaker follow-up system to CPT codes 93293 and 93296 (a ''new'' service without a crosswalk). We asked commenters to provide documentation as to the type and cost of equipment that is used in furnishing these services in the physician office and other information to support any changes from the prior inputs.

Comment: Several commenters agreed with our use of the ''pacemaker interrogation system'' as well as its interim $123,250 price point for CPT codes 93293 and 93296. Only one commenter provided CMS with pricing information for a comparable ''pacemaker monitoring system'' based on three different price quotes, two of which were lower than the interim pricing information.

Response: Based on the information available, we will continue to assign the ''pacemaker interrogation system'' with a price of $123,250 to CPT codes 93293 and 93296. We will continue to review the price of the appropriate cardiac equipment used in both of these codes.

- CPT Codes 97802 and 97803: 97802, *Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes;* and 97803, *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes.*

The above codes were revalued in the CY 2009 PFS final rule with comment period as a result of the AMA RUC Recommendations for Potentially Misvalued Codes (73 FR 69890).

Comment: One commenter stated that inappropriate PE inputs were used for calculating the PE RVUs for Medical Nutrition Therapy codes (CPT codes 97802 and 97803), and requested a revision of the pre-, intra-, and post-service times listed in the PE database. The commenter believes that the pre-service and post-service times for these CPT codes should be increased to 3 minutes pre and 5 minutes post to accurately reflect the time spent.

Response: We agreed with the AMA RUC recommendations for CPT codes 97802 and 97803 in the CY 2009 final rule with comment period (73 FR 69890). We believe that the pre- and post-service times are accurate. If the commenter is concerned about the allocated times for these CPT codes, the commenter should request that the specialty society submit these codes to the AMA RUC for reconsideration.

E. Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2010 (Includes Table 30 Titled ''AMA RUC Recommendations and CMS' Decisions for New and Revised 2010 CPT Codes'')

One aspect of establishing RVUs for 2009 was to assign interim work RVUs for all new and revised CPT codes. As described in our November 25, 1992 notice on the 1993 PFS (57 FR 55951) and in section III.B. of the CY 1997 PFS final rule (61 FR 59505), we established a process, based on recommendations received from the AMA RUC, for establishing interim work RVUs for new and revised codes.

We received work RVU recommendations for 161 new and revised CPT codes from the AMA RUC for 2010. We reviewed the AMA RUC recommendations by comparing them to our reference set or to other comparable services for which work RVUs had previously been established. We also considered the relationships among the new and revised codes for which we received AMA RUC recommendations and agreed with the majority of the relative relationships reflected in the AMA RUC values. Table 30: AMA RUC Recommendations and CMS' Decisions for New and Revised 2010 CPT Codes lists the new or revised CPT codes, and their associated work RVUs, that will be interim in CY 2010. Table 30 includes the following information:

• A ''#'' identifies a new code for CY 2010.

• CPT code. This is the CPT code for a service.

• Modifier. A ''26'' in this column indicates that the work RVUs are for the PC of the code.

• Description. This is an abbreviated version of the narrative description of the code.

• AMA RUC recommendations. This column identifies the work RVUs recommended by the AMA RUC.

• CMS decision. This column indicates whether we agreed or we disagreed with the AMA RUC recommendation. Codes for which we did not accept the AMA RUC recommendation are discussed in greater detail following this table.

• 2010 Work RVUs. This column establishes the interim 2010 work RVUs for physician work.

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TABLE 30: AMA RUC Recommendations and CMS' Decisions for New and Revised 2010 CPT Codes

	CPT Code[1]	New Tech	Mod	Descriptor	AMA RUC WRVU Rec	CMS Decision	CMS 2010 Interim WRVU[2]
#	14301			SKIN TISSUE REARRANGEMENT	12.47	Agree	12.65
#	14302	x		SKIN TISSUE REARRANGE ADD-ON	3.73	Agree	3.73
#	21011			EXC FACE LES SC < 2 CM	2.91	Agree	2.99
#	21012			EXC FACE LES SC = 2 CM	4.37	Agree	4.45
#	21013			EXC FACE TUM DEEP < 2 CM	5.34	Agree	5.42
#	21014			EXC FACE TUM DEEP = 2 CM	7.00	Agree	7.13
	21015			RESECT FACE TUM < 2 CM	9.71	Agree	9.89
#	21016			RESECT FACE TUM = 2 C	15.05	Agree	15.26
#	21552			EXC NECK LES SC = 3 CM	6.41	Agree	6.49
#	21554			EXC NECK TUM DEEP = 5 CM	11.00	Agree	11.13
	21555			EXC NECK LES SC < 3 CM	3.88	Agree	3.96
	21556			EXC NECK TUM DEEP < 5 CM	7.53	Agree	7.66
	21557			RESECT NECK TUM < 5 CM	14.57	Agree	14.75
#	21558			RESECT NECK TUM = 5 CM	21.37	Agree	21.58
	21930			EXC BACK LES SC < 3 CM	4.86	Agree	4.94
#	21931			EXC BACK LES SC = 3 CM	6.80	Agree	6.88
#	21932			EXC BACK TUM DEEP < 5 CM	9.71	Agree	9.82
#	21933			EXC BACK TUM DEEP = 5 CM	11.00	Agree	11.13
	21935			RESECT BACK TUM < 5 CM	15.54	Agree	15.72
#	21936			RESECT BACK TUM = 5 CM	22.34	Agree	22.55
	22900			EXC BACK TUM DEEP < 5 CM	8.21	Agree	8.32
#	22901			EXC BACK TUM DEEP = 5 CM	10.00	Agree	10.11
#	22902			EXC ABD LES SC < 3 CM	4.34	Agree	4.42
#	22903			EXC ABD LES SC > 3 CM	6.31	Agree	6.39
#	22904			RESECT ABD TUM < 5 CM	16.51	Agree	16.69
#	22905			RESECT ABD TUM > 5 CM	21.37	Agree	21.58
#	23071			EXC SHOULDER LES SC > 3 CM	5.83	Agree	5.91
#	23073			EXC SHOULDER TUM DEEP > 5 CM	10.00	Agree	10.13
	23075			EXC SHOULDER LES SC < 3 CM	4.13	Agree	4.21
	23076			EXC SHOULDER TUM DEEP < 5 CM	7.28	Agree	7.41
	23077			RESECT SHOULDER TUM < 5 CM	17.48	Agree	17.66
#	23078			RESECT SHOULDER TUM > 5 CM	22.34	Agree	22.55
	23200			RESECT CLAVICLE TUMOR	22.50	Agree	22.71
	23210			RESECT SCAPULA TUMOR	27.00	Agree	27.21
	23220			RESECT PROX HUMERUS TUMOR	30.00	Agree	30.21
#	24071			EXC ARM/ELBOW LES SC = 3 CM	5.62	Agree	5.70
#	24073			EX ARM/ELBOW TUM DEEP > 5 CM	10.00	Agree	10.13
	24075			EXC ARM/ELBOW LES SC < 3 CM	4.16	Agree	4.24

	CPT Code[1]	New Tech	Mod	Descriptor	AMA RUC WRVU Rec	CMS Decision	CMS 2010 Interim WRVU[2]
	24076			EX ARM/ELBOW TUM DEEP < 5 CM	7.28	Agree	7.41
	24077			RESECT ARM/ELBOW TUM < 5 CM	15.54	Agree	15.72
#	24079			RESECT ARM/ELBOW TUM > 5 CM	20.40	Agree	20.61
	24150			RESECT DISTAL HUMERUS TUMOR	23.25	Agree	23.46
	24152			RESECT RADIUS TUMOR	19.78	Agree	19.99
#	25071			EXC FOREARM LES SC > 3 CM	5.83	Agree	5.91
#	25073			EXC FOREARM TUM DEEP = 3 CM	7.00	Agree	7.13
	25075			EXC FOREARM LES SC < 3 CM	3.88	Agree	3.96
	25076			EXC FOREARM TUM DEEP < 3 CM	6.61	Agree	6.74
	25077			RESECT FOREARM/WRIST TUM<3CM	12.75	Agree	12.93
#	25078			RESECT FOREARM/WRIST TUM=3CM	17.48	Agree	17.69
	25170			RESECT RADIUS/ULNAR TUMOR	22.00	Agree	22.21
#	26111			EXC HAND LES SC > 1.5 CM	5.34	Agree	5.42
#	26113			EXC HAND TUM DEEP > 1.5 CM	7.00	Agree	7.13
	26115			EXC HAND LES SC < 1.5 CM	3.88	Agree	3.96
	26116			EXC HAND TUM DEEP < 1.5 CM	6.61	Agree	6.74
	26117			EXC HAND TUM RA < 3 CM	9.95	Agree	10.13
#	26118			EXC HAND TUM RA > 3 CM	14.57	Agree	14.81
	26250			EXTENSIVE HAND SURGERY	15.00	Agree	15.21
	26260			RESECT PROX FINGER TUMOR	11.00	Agree	11.16
	26262			RESECT DISTAL FINGER TUMOR	8.13	Agree	8.29
#	27043			EXC HIP PELVIS LES SC > 3 CM	6.80	Agree	6.88
#	27045			EXC HIP/PELV TUM DEEP > 5 CM	11.00	Agree	11.13
	27047			EXC HIP/PELVIS LES SC < 3 CM	4.86	Agree	4.94
	27048			EXC HIP/PELV TUM DEEP < 5 CM	8.74	Agree	8.85
	27049			RESECT HIP/PELV TUM < 5 CM	21.37	Agree	21.55
#	27059			RESECT HIP/PELV TUM > 5 CM	29.14	Agree	29.35
	27075			RESECT HIP TUMOR	32.50	Agree	32.71
	27076			RESECT HIP TUM INCL ACETABUL	40.00	Agree	40.21
	27077			RESECT HIP TUM W/INNOM BONE	45.00	Agree	45.21
	27078			RSECT HIP TUM INCL FEMUR	32.00	Agree	32.21
	27327			EXC THIGH/KNEE LES SC < 3 CM	3.88	Agree	3.96
	27328			EXC THIGH/KNEE TUM DEEP <5CM	8.74	Agree	8.85
	27329			RESECT THIGH/KNEE TUM < 5 CM	15.54	Agree	15.72
#	27337			EXC THIGH/KNEE LES SC > 3 CM	5.83	Agree	5.91
#	27339			EXC THIGH/KNEE TUM DEEP >5CM	11.00	Agree	11.13

	CPT Code[1]	New Tech	Mod	Descriptor	AMA RUC WRVU Rec	CMS Decision	CMS 2010 Interim WRVU[2]
#	27364			RESECT THIGH/KNEE TUM >5 CM	24.28	Agree	24.49
	27365			RESECT FEMUR/KNEE TUMOR	32.00	Agree	32.21
	27615			RESECT LEG/ANKLE TUM < 5 CM	15.54	Agree	15.72
#	27616			RESECT LEG/ANKLE TUM > 5 CM	19.42	Agree	19.63
	27618			EXC LEG/ANKLE TUM < 3 CM	3.88	Agree	3.96
	27619			EXC LEG/ANKLE TUM DEEP <5 CM	6.80	Agree	6.91
#	27632			EXC LEG/ANKLE LES SC > 3 CM	5.83	Agree	5.91
#	27634			EXC LEG/ANKLE TUM DEEP >5 CM	10.00	Agree	10.13
	27645			RESECT TIBIA TUMOR	27.00	Agree	27.21
	27646			RESECT FIBULA TUMOR	23.00	Agree	23.21
	27647			RESECT TALUS/CALCANEUS TUM	20.10	Agree	20.26
#	28039			EXC FOOT/TOE TUM SC > 1.5 CM	5.34	Agree	5.42
#	28041			EXC FOOT/TOE TUM DEEP >1.5CM	7.00	Agree	7.13
	28043			EXC FOOT/TOE TUM SC < 1.5 CM	3.88	Agree	3.96
	28045			EXC FOOT/TOE TUM DEEP <1.5CM	5.34	Agree	5.45
	28046			RESECT FOOT/TOE TUMOR < 3 CM	12.20	Agree	12.38
#	28047			RESECT FOOT/TOE TUMOR > 3 CM	17.24	Agree	17.45
	28171			RESECT TARSAL TUMOR	16.25	Agree	16.41
	28173			RESECT METATARSAL TUMOR	14.00	Agree	14.16
	28175			RESECT PHALANX OF TOE TUMOR	8.13	Agree	8.29
#	29581			APPLY MULTLAY COMPRS LWR LEG	0.60	Agree	0.60
#	31626	x		BRONCHOSCOPY W/MARKERS	4.16	Agree	4.16
#	31627	x		NAVIGATIONAL BRONCHOSCOPY	2.00	Agree	2.00
#	32552			REMOVE LUNG CATHETER	2.50	Agree	2.53
#	32553	x		INS MARK THOR FOR RT PERQ	3.80	Agree	3.80
	32560			TREAT PLEURODESIS W/AGENT	1.54	Agree	1.54
#	32561			LYSE CHEST FIBRIN INIT DAY	1.39	Agree	1.39
#	32562			LYSE CHEST FIBRIN SUBQ DA	1.24	Agree	1.24
#	33782			NIKAIDOH PROC	60.00	Agree	60.08
#	33783			NIKAIDOH PROC W/OSTIA IMPLT	65.00	Agree	65.08
#	33981			REPLACE VAD PUMP EXT	Contractor Priced	Agree	Contractor Priced
#	33982			REPLACE VAD INTRA W/O BP	Contractor Priced	Agree	Contractor Priced

	CPT Code[1]	New Tech	Mod	Descriptor	AMA RUC WRVU Rec	CMS Decision	CMS 2010 Interim WRVU[2]
#	33983			REPLACE VAD INTRA W/BP	Contractor Priced	Agree	Contractor Priced
#	36147			ACCESS AV DIAL GRFT FOR EVAL	3.72	Agree	3.72
#	36148			ACCESS AV DIAL GRFT FOR PROC	1.00	Agree	1.00
#	37761			LIGATE LEG VEINS OPEN	9.00	Agree	9.13
#	43281	x		LAP PARAESOPHAG HERN REPAIR	26.50	Agree	26.60
#	43282	x		LAP PARAESOPH HER RPR W/MESH	30.00	Agree	30.10
#	43775	x		LAP SLEEVE GASTRECTOMY	21.40	Agree	21.56
#	45171			EXC RECT TUM TRANSANAL PART	8.00	Agree	8.13
#	45172			EXC RECT TUM TRANSANAL FULL	12.00	Agree	12.13
#	46707	x		REPAIR ANORECTAL FIST W/PLUG	6.30	Disagree	6.39
#	49411	x		INS MARK ABD/PEL FOR RT PERQ	3.82	Agree	3.82
#	51727		26	CYSTOMETROGRAM W/UP	2.11	Agree	2.11
#	51728		26	CYSTOMETROGRAM W/VP	2.11	Agree	2.11
#	51729		26	CYSTOMETROGRAM W/VP&UP	2.51	Agree	2.11
#	53855	x		INSERT PROST URETHRAL STENT	1.64	Agree	1.64
#	57426	x		REVISE PROSTH VAG GRAFT LAP	14.15	Agree	14.30
#	63661			REMOVE SPINE ELTRD PERQ ARAY	5.03	Agree	5.08
#	63662			REMOVE SPINE ELTRD PLATE	10.87	Agree	11.00
#	63663			REVISE SPINE ELTRD PERQ ARAY	7.70	Agree	7.75
#	63664			REVISE SPINE ELTRD PLATE	11.39	Agree	11.52
#	64490			INJ PARAVERT F JNT C/T 1 LEV	1.82	Agree	1.82
#	64491			INJ PARAVERT F JNT C/T 2 LEV	1.16	Agree	1.16
#	64492			INJ PARAVERT F JNT C/T 3 LEV	1.16	Agree	1.16
#	64493			INJ PARAVERT F JNT L/S 1 LEV	1.52	Agree	1.52
#	64494			INJ PARAVERT F JNT L/S 2 LEV	1.00	Agree	1.00
#	64495			INJ PARAVERT F JNT L/S 3 LEV	1.00	Agree	1.00
#	74261	x		CT COLONOGRAPHY, W/O DYE	2.40	Disagree	2.28
#	74262	x		CT COLONOGRAPHY, W/DYE	2.50	Agree	2.50
#	74263	x		CT COLONOGRAPHY, SCREEN	2.28	Agree (a)	2.28
#	75565			CARD MRI VEL FLW MAP ADD-ON	0.25	Agree	0.25
#	75571	x		CT HRT W/O DYE W/CA TEST	0.58	Agree	0.58
#	75572	x		CT HRT W/3D IMAGE	1.75	Agree	1.75
#	75573	x		CT HRT W/3D IMAGE, CONGEN	2.55	Agree	2.55

	CPT Code[1]	New Tech	Mod	Descriptor	AMA RUC WRVU Rec	CMS Decision	CMS 2010 Interim WRVU[2]
#	75574	x		CT ANGIO HRT W/3D IMAGE	2.40	Agree	2.40
#	75791			AV DIALYSIS SHUNT IMAGING	1.71	Agree	1.71
#	77338			DESIGN MLC DEVICE FOR IMRT	4.29	Agree	4.29
#	78451		26	HT MUSCLE IMAGE SPECT, SING	1.40	Disagree	1.38
#	78452		26	HT MUSCLE IMAGE SPECT, MULT	1.75	Disagree	1.62
#	78453		26	HT MUSCLE IMAGE,PLANAR,SING	1.00	Agree	1.00
#	78454		26	HT MUSC IMAGE, PLANAR, MULT	1.34	Agree	1.34
#	88387	x	26	TISS EXAM MOLECULAR STUDY	0.62	Agree	0.62
#	88388	x	26	TISS EX MOLECUL STUDY ADD-ON	0.45	Agree	0.45
#	92540		26	BASIC VESTIBULAR EVALUATION	1.50	Agree	1.50
#	92550			TYMPANOMETRY & REFLEX THRESH	0.35	Agree	0.35
#	92570			ACOUSTIC IMMITTANCE TESTING	0.55	Agree	0.55
	93701			BIOIMPEDANCE, CV ANALYSIS	0.00	Agree	0.00
#	93750			INTERROGATION VAD, IN PERSON	0.92	Agree	0.92
#	94011	x	26	UP TO 2 YRS OLD, SPIROMETRY	2.00	Agree	2.00
#	94012	x	26	= 2 YRS, SPIROMTRY W/DILATOR	3.10	Agree	3.10
#	94013	x	26	= 2 YRS, LUNG VOLUMES	0.66	Agree	0.66
#	95905	x	26	MOTOR/SENS NRVE CONDUCT TEST	0.05	Agree	0.05
	96570			PHOTODYNMC TX, 30 MIN ADD-ON	1.10	Agree	1.10
	96571			PHOTODYNAMIC TX, ADDL 15 MIN	0.55	Agree	0.55
	99358			PROLONG SERVICE W/O CONTACT	2.10	Agree	2.10
	99359			PROLONG SERV W/O CONTACT ADD	1.00	Agree	1.00

New CPT Code

[1] All CPT codes copyright 2009 American Medical Association

[2] Work RVU values recommended by CMS may differ from the AMA RUC recommended value due to work increases in 10 and 90 day global codes as a result of the elimination of the consultation codes.

(a) AMA RUC-recommended work RVU accepted but coverage status of code is non-covered. See code discussion in section F. Discussion of Codes and AMA RUC Recommendations.

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F. Discussion of Codes and AMA RUC Recommendations

The following is an explanation of our rationale for not accepting particular AMA RUC-recommended work RVUs. It is arranged by type of service in CPT order and refers only to work RVUs.

1. Excision of Soft Tissue and Bone Excision of Soft Tissue and Bone Tumors

In February 2009, the CPT Editorial Panel approved the coding proposal submitted by the Soft Tissue Tumor and Bone Workgroup, which revised and expanded the soft tissue tumor and bone tumor section codes to more accurately describe the services being provided and to address the concerns raised by the AMA RUC during the Third Five-Year Review. For CY 2010, the CPT Editorial Panel split 31 codes into 62 codes differentiated by the size of the excised lesion, 18 codes were revised, and 12 additional codes were created. These codes were created to fill in anatomic gaps in the coding convention for excision of soft tissue tumors.

The survey results for these codes reflected that the majority of these services, while previously performed as outpatient services (based on 2007 Medicare claims data), had now been valued as inpatient services by the AMA RUC. We believe the Medicare claims data are accurate and do not agree with the inclusion of inpatient services in these codes, particularly, the smaller sized tumors. We have concerns about the additional minutes added to the pre-service time for positioning of the patient. We believe the additional minutes are excessive and request that the AMA RUC re-examine the minutes allocated for positioning of the patient. We also have concerns about the projected utilization for these codes. We understand that the specialty society had difficulty in estimating the frequency split for current codes and frequency estimates for new codes and for the majority of the codes, estimated that the smaller sized tumors would be reported 90 percent of the time, while the larger tumors would be reported only 10 percent of the time. The AMA RUC recommended that these services should be re-reviewed to determine the accuracy of these utilization assumptions once 2 years of frequency data from Medicare have been obtained. We agree with the AMA RUC and plan to monitor the frequency data for these codes and may propose further changes to the work RVUs in the future based upon this data.

Although we have serious concerns with the valuation of these codes for 2010, and due to the comments received on the site of service anomaly codes, we have agreed to accept the AMA RUC-recommended values for these codes on an interim basis. However, we will work with the AMA RUC to address our concerns about the valuation of these codes and will consider whether it would be appropriate to propose further changes in future rulemaking.

We note that the CPT 2010 instructions regarding the use of the excision and resection of soft tissue and bone tumor codes advise that a complex repair may be separately reported. Longstanding Medicare policy generally includes payment for all simple, intermediate, and complex repairs of procedural incisions. Therefore, Medicare will not separately pay for complex repairs for these codes.

2. Fistula Plug

For CY 2010, the AMA RUC-recommended 6.30 work RVUs for CPT code 46707, *Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS]).* We disagree with the AMA RUC-recommended value and believe it should be valued the same as the reference code, CPT code 46280, *Surgical treatment of anal fistula (fistulectomy/fistulotomy); complex or multiple, with or without placement of seton,* which is assigned 6.28 work RVUs. Although CPT code 46707 has 2 minutes less pre-service time and 5 minutes less intra- and post-service time than the reference code, we believe these two codes are similar and should be valued the same. While the AMA RUC noted that the intra-service time intensity is greater in CPT code 46707 than in the reference code, we do not believe this rationale justifies a higher recommended work RVU for CPT code 46707. Therefore, we have assigned 6.28 work RVUs to CPT code 46707.

3. Computed Tomography Colongraphy

For CY 2010 the AMA RUC recommended 2.40 work RVUs for CPT code 74261, *Computed tomographic (CT), colonography, diagnostic, including image postprocessing; without contrast material.* We disagree with the AMA RUC-recommended value and believe this code is comparable to CPT code 74263, *Computed tomographic (CT) colonography, screening, including image postprocessing,* which virtually has the same description of work, pre-, intra-, and post-service time for which the AMA RUC recommended 2.28 work RVUs. Therefore we have assigned 2.28 work RVUs to CPT code 74261.

CPT code 74263 was previously reported using Category III code 0066T, *Computed tomographic (CT) colonography (ie, virtual colonoscopy); screening,* which has been deleted and was a non-covered code. Based on the descriptors, these CPT codes describe services that include screening services. In general, screening services under Medicare are considered to be those services provided to beneficiaries in the absence of signs or symptoms of illness or injury; therefore, to the extent that the services described by CPT code 74263 have a screening element, the screening component would not meet the statutory requirements for coverage under section 1862(a)(1)(A) of the Act. Screening services are not covered by Medicare without specific statutory authority, such as has been provided for mammography, diabetes, and colorectal cancer screening. Accordingly, we will not recognize this CPT codes that incorporates screening for payment under the PFS.

Although we have accepted the AMA RUC recommendation for this service, we have assigned a status indicator of ''N'' (Non-covered) to CPT code 74263 since the code descriptor describe services that include screening services.

4. Myocardial Perfusion Imaging

For CY 2010 the AMA RUC recommended 1.40 work RVUs for CPT code 78451, *Myocardial perfusion imaging; tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)* and 1.75 work RVUs for CPT code 78452, *Myocardial perfusion imaging; tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection.*

For CPT code 78451, it was unclear what methodology the AMA RUC used to calculate the recommended RVU and, therefore, we disagree with the AMA RUC-recommended value. We believe the work RVU for the 25th percentile is more appropriate and have assigned 1.38 work RVUs to CPT code 78451.

For CPT code 78452, we disagree with the reference code used, CPT code 70496, *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing,* which is assigned 1.75. We believe CPT code 78452 is comparable to CPT code 73219,

Magnetic resonance (e.g., proton) imaging, upper extremity, other than joint; with contrast material(s), which is assigned 1.62 work RVUs and the same pre-, intra-, and post-service time. Therefore, we have assigned 1.62 work RVUs to CPT code 78452.

5. Comments Received on New CPT Codes for CY 2010

We received comments on new CPT codes for CY 2010. Since these are new codes for CY 2010, they are subject to comment as part of this final rule. To the extent that commenters have additional concerns, we would encourage them to submit comments in response to this rule.

6. Other AMA RUC Recommendations Received: H1N1 Immunization Administration

The CPT Editorial Panel created CPT code 90470, *Immunization administration (intramuscular, intranasal), including counseling when performed to assist the public health effort to vaccinate for H1N1.* The AMA RUC reviewed this service and recommended 0.20 work RVUs. However, for Medicare payment purposes, we will not recognize this code since we created a specific HCPCS code *(G9141, Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family))* for this service that was effective September 1, 2009. We have assigned a status indicator of ''N'' (Non-covered) to this service and will publish the AMA RUC-recommended value in accordance with our practice for non-covered CPT codes.

G. Additional Coding Issues

1. Reduction in the Technical Component (TC) Payment for Imaging Services Paid Under the PFS to the Outpatient Department (OPD) Amount

Effective January 1, 2007, section 5102(b)(1) of the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA) capped the TC of most imaging services paid under the PFS at the amount paid under the Outpatient Prospective Payment System (OPPS) (71 FR 69659).

The list of codes subject to the OPPS cap has been revised to reflect new and deleted CPT codes for 2010. The complete list of codes subject to the OPPS cap is in Addendum H.

H. Establishment of Interim PE RVUs for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System (HCPCS) Codes for 2010

We have developed a process for establishing interim PE RVUs for new and revised codes that is similar to that used for work RVUs. Under this process, the AMA RUC recommends the PE direct inputs (the staff time, supplies and equipment) associated with each new code. CMS reviews the recommendations in a manner similar to our evaluation of the RUC-recommended work RVUs. The AMA RUC recommendations on the PE inputs for the new and revised CY 2010 codes were submitted to CMS as interim recommendations.

We have accepted, in the interim, the PE recommendations submitted by the RUC for the codes listed in Table 30: AMA RUC Recommendations and CMS' Decisions for New and Revised 2010 CPT Codes.

IV. Physician Self-Referral Prohibition: Annual Update to the List of CPT/HCPCS Codes

A. General

Section 1877 of the Act prohibits a physician from referring a Medicare beneficiary for certain designated health services (DHS) to a health care entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. Section 1877 of the Act also prohibits the DHS entity from submitting claims to Medicare or billing the beneficiary or any other entity for Medicare DHS that are furnished as a result of a prohibited referral.

Section 1877(h)(6) of the Act and § 411.351 of our regulations specify that the following services are DHS:

- Clinical laboratory services.
- Physical therapy services.
- Occupational therapy services.
- Outpatient speech-language pathology services.
- Radiology services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment, and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

B. Annual Update to the Code List

1. Background

In § 411.351, we specify that the entire scope of four DHS categories is defined in a list of CPT/HCPCS codes (the Code List), which is updated annually to account for changes in the most recent CPT and HCPCS publications. The DHS categories defined and updated in this manner are:

- Clinical laboratory services.
- Physical therapy, occupational therapy, and outpatient speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.

The Code List also identifies those items and services that may qualify for either of the following two exceptions to the physician self-referral prohibition:

- EPO and other dialysis-related drugs furnished in or by an ESRD facility (§ 411.355(g)).
- Preventive screening tests, immunizations, or vaccines (§ 411.355(h)).

The Code List was last updated in the CY 2009 PFS final rule with comment period (73 FR 69726) and in a subsequent correction notice (73 FR 80302).

2. Response to Comments

We received one public comment relating to the Code List that became effective January 1, 2009. The comment involved CPT code 0019T, *Extracorporeal shock wave involving musculosketal system, not otherwise specified, low energy.*

Comment: A commenter wrote concerning the classification of CPT code 0019T as ''physical therapy.'' The commenter stated that the use of extracorporeal shock wave generators is restricted by Federal law to sale by or on the order of a physician. The commenter stated that ''the practice of extracorporeal shock wave therapy by *non qualified providers* poses a considerable risk to the safety of the patient and a likely reduction in the effectiveness in the treatment * * *'' (emphasis added by commenter).

Response: The commenter seemed to be objecting to the classification of CPT code 0019T as physical therapy, not only for the purpose of the physician self-referral Code List, but also for broader Medicare payment purposes. We believe that the commenter also has concerns about physical therapists ordering extracorporeal shock wave therapy even though a physician must sign the plan of care. While we appreciate the commenter's concerns,

the concerns encompass issues that are outside the scope of this rule and cannot be addressed here. The purpose of our update is to announce changes to the Code List to account for changes in the most recent CPT and HCPCS publications or Medicare policies. We added CPT 0019T to the physician self-referral Code List effective January 1, 2006 (see 70 FR 70297 and 70472) under the category of ''Physical Therapy, Occupational Therapy, and Speech-language Pathology'' because it was added to the CY 2006 PFS for payment purposes, was included as a ''therapy'' code in Medicare Transmittal 805, ''Annual Update to the Therapy Code List'' that was effective January 1, 2006, and meets the definition of physical therapy services that is set forth in § 411.351. Thus, we believe the code is properly included as a physical therapy service on our Code List.

3. Revisions Effective for 2010

The updated, comprehensive Code List effective January 1, 2010 appears as Addendum I in this final rule with comment period and is available on our Web site at *http://www.cms.hhs.gov/PhysicianSelfReferral/11_List_of_Codes.asp#TopOfPage.* Additions and deletions to the Code List conform the Code List to the most recent publications of CPT and HCPCS and to changes in Medicare coverage policy and payment status.

Tables 31 and 32 identify the additions and deletions, respectively, to the comprehensive Code List that was published in Addendum J of the CY 2009 PFS final rule (73 FR 70214 through 70237) and revised in a subsequent correction notice (73 FR 80302). Tables 31 and 32 also identify the additions and deletions to the lists of codes used to identify the items and services that may qualify for the exceptions in § 411.355(g) (regarding EPO and other dialysis-related outpatient prescription drugs furnished in or by an ESRD facility) and in § 411.355(h) (regarding preventive screening tests, immunizations, and vaccines).

In Table 31, we specify additions that generally reflect new CPT and HCPCS codes that become effective January 1, 2010, or that became effective since our last update. We also are adding HCPCS codes G0416 through G0419 that represent pathology codes for prostate needle saturation biopsy sampling to the ''Clinical Laboratory Services'' category of the Code List. These codes became effective January 1, 2009, and were discussed in the preamble of the CY 2009 PFS final rule (73 FR 69751). We inadvertently failed to add them to the Code List update that was published in that rule.

Table 32 reflects the deletions necessary to conform the Code List to the most recent publications of the CPT and HCPCS. In addition, we are making other deletions based on changes in Medicare coverage and payment status. We are deleting CPT code 0085T, representing a breath test for heart transplant rejection, since this code is no longer payable by Medicare. We also are deleting CPT code 95992, a code for canalith repositioning procedures, as it will be designated as ''invalid'' for Medicare purposes as discussed in section II.E.1 of this preamble.

We will consider comments regarding the codes listed in Tables 31 and 32. Comments will be considered if we receive them by the date specified in the ''DATES'' section of this final rule with comment period. We will not consider any comment that advocates a substantive change to any of the DHS defined in § 411.351.

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TABLE 31: Additions to the Physician Self-Referral List of CPT[1]/HCPCS Codes

CLINICAL LABORATORY SERVICES	
G0416	Sat biopsy prostate 1-20 spc
G0417	Sat biopsy prostate 21-40
G0418	Sat biopsy prostate 41-60
G0419	Sat biopsy prostate: >60
G0430	Drug screen multi class
G0431	Drug screen single class
G9143	Warfarin respon genetic test
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	
[no additions]	
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
74261	Ct colonography, w/o dye
74262	Ct colonography, w/dye
75565	Card mri vel flw map add-on
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
78451	Ht muscle image spect, sing
78452	Ht muscle image spect, mult
78453	Ht muscle image,planar,sing
78454	Ht musc image, planar, mult
RADIATION THERAPY SERVICES AND SUPPLIES	
32553	Ins mark thor for rt perq
49411	Ins mark abd/pel for rt perq
77338	Design mlc device for imrt
A9604	Sm 153 lexidronam
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS	
Q0139	Ferumoxytol, esrd use
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
[no additions]	

[1]CPT codes and descriptions only are copyright 2009 AMA. All rights are reserved and applicable FARS/DFARS clauses apply.

TABLE 32: Deletions to the Physician Self-Referral List of CPT[1]/HCPCS Codes

CLINICAL LABORATORY SERVICES	
0064T	Spectroscop eval expired gas
0085T	Breath test heart reject
0087T	Sperm eval hyaluronan
0194T	Procalcitonin (PCT)
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	
95992	Canalith repositioning proc
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
0067T	Ct colonography; dx
0144T	Ct heart wo dye; qual calc
0145T	Ct heart w/wo dye funct
0146T	Ccta w/wo dye
0147T	Ccta w/wo, quan calcium
0148T	Ccta w/wo, strxr
0149T	Ccta w/wo, strxr quan calc
0150T	Ccta w/wo, disease strxr
0151T	Ct heart funct add-on
78460	Heart muscle blood, single
78461	Heart muscle blood, multiple
78464	Heart image (3d), single
78465	Heart image (3d), multiple
78478	Heart wall motion add-on
78480	Heart function add-on
RADIATION THERAPY SERVICES AND SUPPLIES	
A9605	Sm 153 lexidronm
DRUGS USED BY PATIENTS UNDERGOING DIALYSIS	
[no deletions]	
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
[no deletions]	

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V. Physician Fee Schedule Update for CY 2010

A. Physician Fee Schedule Update

The PFS update is determined using a formula specified in section 1848(d)(4) of the Act. Section 101 of the MIEA–TRHCA provided a 1-year increase in the CY 2007 conversion factor (CF) and specified that the CF for CY 2008 must be computed as if the 1-year increase had never applied. Section 101 of the MMSEA provided a 6-month increase in the CY 2008 CF, from January 1, 2008, through June 30, 2008, and specified that the CF for the remaining portion of 2008 and the CFs for CY 2009 and subsequent years must be computed as if the 6-month increase had never applied. Section 131 of the MIPPA extended the 6-month increase that was applicable to the CF for the first half of CY 2008 to the entire year, provided for a 1.1 percent increase to the CY 2009 CF, and specified that the CFs for CY 2010 and subsequent years must be computed as if the increases for CYs 2007, 2008, and 2009 had never applied.

If section 101 of the MIEA–TRHCA had not been enacted, the CY 2007 CF update would have been −5.0 percent (0.94953), as published in the CY 2007 PFS final rule with comment period (71 FR 69760). If section 101 of the MMSEA had not been enacted, the CY 2008 CF update would have been −10.1 percent (0.89896), as published in the CY 2008 PFS final rule with comment period (72 FR 66383).

If section 131 of the MIPPA had not been enacted, the CY 2009 CF update would have been −15.1 percent (0.84941), as discussed in the CY 2009 PFS final rule with comment period (73 FR 69900).

For CY 2010, the Medicare Economic Index (MEI) is equal to 1.2 percent (1.012). The update adjustment factor (UAF) is −7.0 percent. Our calculations of these figures are explained below in this section.

In order to determine the 2010 PFS CF update, the CFs for 2007, 2008, and 2009 must be calculated as if the various legislative changes to the CFs for those years had not occurred. Consistent with the formula specified by the statute, the CY 2010 CF update is −21.2 percent (0.78760). Our calculations are explained below in this section.

B. The Percentage Change in the Medicare Economic Index (MEI)

The Medicare Economic Index (MEI) is authorized by section 1842(b)(3) of the Act, which states that prevailing charge levels beginning after June 30, 1973 may not exceed the level from the previous year except to the extent that the Secretary finds, on the basis of appropriate economic index data, that the higher level is justified by year-to-year economic changes.

The MEI measures the weighted-average annual price change for various inputs needed to produce physicians' services. The MEI is a fixed-weight input price index, with an adjustment for the change in economy-wide multifactor productivity. This index, which has CY 2000 base year weights, is comprised of two broad categories: (1) physician's own time; and (2) physician's practice expense (PE).

The physician's own time component represents the net income portion of business receipts and primarily reflects the input of the physician's own time into the production of physicians' services in physicians' offices. This category consists of two subcomponents: (1) wages and salaries; and (2) fringe benefits.

The physician's PE category represents nonphysician inputs used in the production of services in physicians' offices. This category consists of wages and salaries and fringe benefits for nonphysician staff and other nonlabor inputs. The physician's PE component also includes the following categories of nonlabor inputs: office expense; medical materials and supplies; professional liability insurance; medical equipment; prescription drugs; and other expenses. The components are adjusted to reflect productivity growth in physicians' offices by the 10-year moving average of productivity in the private nonfarm business sector.

Table 33 presents a listing of the MEI cost categories with associated weights and percent changes for price proxies for the 2010 update. For CY 2010, the increase in the MEI is 1.2 percent, which includes a 1.3 percent productivity offset based on the 10-year moving average of multifactor productivity. This is the result of a 3.2 percent increase in physician's own time and a 1.8 percent increase in physician's PE. Within the physician's PE, the largest increase occurred in prescription drugs, which increased 7.1 percent.

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TABLE 33: Increase in the Medicare Economic Index Update for CY 2010[1]

Cost Categories and Price Measures	CY 2000 Weights[2]	CY 2010 Percent Changes
Medicare Economic Index Total, productivity adjusted[3]	N/A	1.2
Productivity: 10-year moving average of multifactor productivity, private nonfarm business sector[3]	N/A	1.3
Medicare Economic Index Total, without productivity adjustment	100.000	2.5
1. Physician's Own Time[4]	52.466	3.2
a. Wages and Salaries: Average Hourly Earnings, private Nonfarm	42.730	3.5
b. Fringe Benefits: Employment Cost Index, benefits, private Nonfarm[4]	9.735	1.8
2. Physician's Practice Expense[4]	47.534	1.8
a. Nonphysician Employee Compensation	18.653	2.6
(1) Wages and Salaries: Employment Cost Index, wages and salaries, weighted by occupation	13.808	2.7
(2) Fringe Benefits: Employment Cost Index, fringe benefits, weighted by occupation	4.845	2.4
b. Office Expense: Consumer Price Index for Urban Areas (CPI-U), housing	12.209	2.2
c. Drugs and Medical Materials and Supplies	4.319	4.7
(1) Medical Materials and Supplies: Producer Price Index (PPI), surgical appliances and supplies/CPI-U, medical equipment and supplies (equally weighted)	2.011	1.1
(2) Pharmaceuticals: Producer Price Index (PPI ethical prescription drugs)	2.308	7.1
d. Professional Liability Insurance: Professional liability insurance Premiums[5]	3.865	-3.6
e. Medical Equipment: PPI, medical instruments and equipment	2.055	0.8
f. Other Expenses	6.433	2.0

1. The rates of historical change are estimated for the 12-month period ending June 30, 2009, which is the period used for computing the CY 2010 update. The price proxy values are based upon the latest available Bureau of Labor Statistics data as of September 5, 2009.
2. The weights shown for the MEI components are the 2000 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for CY 2000. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 2000 weight. The sum of these products (weights multiplied by the price index levels) over all cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.
3. These numbers may not sum due to rounding and the multiplicative nature of their relationship.
4. The measures of productivity, average hourly earnings, Employment Cost Indexes, as well as the various Producer and CPIs can be found on the BLS Web site at http://stats.bls.gov .
5. Derived from data collected from several major insurers (the latest available historical percent change data are for the period ending second quarter of 2009).

C. The Update Adjustment Factor (UAF)

Section 1848(d) of the Act provides that the PFS update is equal to the product of the MEI and the UAF. The UAF is applied to make actual and target expenditures (referred to in the statute as ''allowed expenditures'') equal. Allowed expenditures are equal to actual expenditures in a base period updated each year by the sustainable growth rate (SGR). The SGR sets the annual rate of growth in allowed expenditures and is determined by a formula specified in section 1848(f) of the Act.

1. Calculation under Current Law

Under section 1848(d)(4)(B) of the Act, the UAF for a year beginning with CY 2001 is equal to the sum of the following—

• *Prior Year Adjustment Component.* An amount determined by—

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (the year prior to the year for which the update is being determined) and the amount of the actual expenditures for those services for that year;

+ Dividing that difference by the amount of the actual expenditures for those services for that year; and

+ Multiplying that quotient by 0.75.

• *Cumulative Adjustment Component.* An amount determined by—

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for those services during that period;

+ Dividing that difference by actual expenditures for those services for the prior year as increased by the SGR for the year for which the UAF is to be determined; and

+ Multiplying that quotient by 0.33.

Section 1848(d)(4)(E) of the Act requires the Secretary to recalculate allowed expenditures consistent with section 1848(f)(3) of the Act. Section 1848(f)(3) specifies that the SGR (and, in turn, allowed expenditures) for the upcoming CY (CY 2010 in this case), the current CY (that is, CY 2009) and the preceding CY (that is, CY 2008) are to be determined on the basis of the best data available as of September 1 of the current year. Allowed expenditures for a year generally are estimated initially and subsequently revised twice. The second revision occurs after the CY has ended (that is, we are making the second revision to 2008 allowed expenditures in this final rule with comment).

In the CY 2010 PFS proposed rule (74 FR 33650), we noted that section 1848(f)(4)(A) of the Act provides the Secretary with clear discretion to determine what items and services should be included in the definition of ''physicians' services'' for purposes of determining allowed expenditures and the SGR. As the statute affords the Secretary clear discretion to revise the definition of ''physicians' services'', we proposed to remove physician-administered drugs from the definition of ''physicians' services'' in section 1848(f)(4)(A) of the Act for purposes of computing the SGR and levels of allowed expenditures and actual expenditures in all future years. Furthermore, given the past effect of spending growth for physician-administered drugs on future PFS updates, in order to effectuate fully the Secretary's policy decision to remove drugs from the definition of ''physicians' services'', we also indicated that we believed it was reasonable to remove drugs from the calculation of allowed and actual expenditures for all prior years.

In the proposed rule (74 FR 33651), we noted that the term ''actual expenditures'' is not defined in the statute, nor are there any statutory limitations on the Secretary's ability to recompute actual expenditures to reflect changes in the amount of actual expenditures. On several occasions, we have made revisions to the amount of actual expenditures to reflect new information regarding spending on physicians' services. In order to eliminate the disproportionate impact that the large past increases in the costs attributable to physician-administered drugs would otherwise have upon future PFS updates, we proposed to remove drugs from the calculation of allowed and actual expenditures under sections 1848(d)(3)(C) and 1848(d)(4) of the Act retrospectively to the 1996/1997 base year. Further, we proposed to remove drugs from the calculation of the SGR beginning with 2010.

Comment: Commenters strongly supported our proposal to remove drugs from the calculation of allowed and actual expenditures retrospectively to the 1996/1997 base year and our proposal to remove drugs from the calculation of the SGR beginning with 2010. Many noted that they have been requesting this change for years. However, all commenters expressed concerns about the estimated negative update for CY 2010 of approximately −21 percent, followed by multiple years of negative physician updates of approximately −5 percent. Commenters described how they believe the SGR and update formulas are flawed, and they stated their belief that the magnitude of the 1-year reduction, followed by multiple years of continued reductions, will impair beneficiary access to quality care. Many commenters urged us to work with Congress to revise or replace the physician update and SGR formulas. Some of these commenters suggested alternative methodologies for updating physician payments, and a number of them specifically expressed their support for the SGR-related provisions of H.R. 3200. A few commenters suggested using our administrative authority to implement additional changes that would further lessen the negative impact. The AMA requested that we publish in our final rule estimates of the annual updates for 2011 through 2014.

Response: As discussed in the proposed rule (74 FR 33650), the magnitude of the estimated 1-year reduction led us to reexamine administrative actions that the Secretary could take to lessen the potential for repeated further reductions in the PFS update. We explored the breadth of options available under current authority including an assessment of whether the cost of physician-administered drugs should continue to be included in actual expenditures, allowed expenditures and the SGR. As the statute affords the Secretary clear discretion to define ''physicians' services'' for purposes of determining allowed expenditures and the SGR (section 1848(f)(4)(A) of the Act), we proposed to remove physician-administered drugs from the definition of ''physicians' services'' in section 1848(f)(4)(A) of the Act for purposes of computing the SGR and the levels of allowed expenditures and actual expenditures in all future years. Moreover, given the past effect of spending growth for physician-administered drugs on future PFS updates, in order to effectuate fully the Secretary's policy decision to remove drugs from the definition of physicians' services in section 1848(f)(4)(A) of the Act, we proposed to remove drugs from the calculation of allowed and actual expenditures under section 1848(d)(3)(C) and 1848(d)(4) of the Act retrospectively to the 1996 base year in order to eliminate the disproportionate impact that the large past increases in the costs attributable to physician-administered drugs would otherwise have upon future PFS updates. (See 74 FR 33651 for a more detailed

explanation of our legal authority for this proposal). We received no public comments that disagreed with these proposals.

Accordingly, we are removing physician-administered drugs from the calculation of allowed and actual expenditures under sections 1848(d)(3)(C) and 1848(d)(4) of the Act for CY 2010 and retrospectively to the 1996/1997 base year in this final rule. We are also finalizing our proposal to remove drugs from the calculation of the SGR beginning with 2010.

With respect to the many suggestions we received in the public comments asking the Secretary and the Congress to do more to avert the reduction in PFS payments for 2010 and future years, all other options suggested in the comments would require a change to the statute. We also received a comment requesting that we include estimates of the updates from 2010 through 2014 in this final rule. We are providing the 2010 update in the final rule, but are not providing estimates of the updates for later years as future updates will vary depending on the baseline used and will also change as additional information becomes available.

Our decision to remove drugs from the allowed and actual expenditures and the SGR will have no effect on the 2010 PFS update of −21.3 percent because removing drugs from allowed and actual expenditures retroactively to the base year changes the UAF for CY 2010 from −30.9 percent to −8.8 percent. As the statute limits the UAF for a year to −7.0 percentage points, the UAF would be −7.0 percent irrespective of whether drugs are included or excluded from allowed and actual expenditures retroactive to the base year. Although the magnitude of future updates remains uncertain, as the following analysis demonstrates, it is clear that our proposal to remove drugs from allowed expenditures, actual expenditures, and the SGR will make a positive PFS update far more likely. Removing drugs from allowed and actual expenditures for all years and from future SGRs reduces the difference between cumulative allowed and actual expenditures from $71.8 billion to $19.4 billion or by over $50 billion. Future PFS updates will only have to be reduced by $19.4 billion rather than $71.8 billion to equate actual and allowed expenditures. The UAF for 2010 changes from −30.9 percent to −8.8 percent, but is limited to −7.0 percent under either scenario. If physician-administered drugs were to remain included in allowed and actual expenditures, the UAF would be expected to be at the maximum reduction of −7.0 percent for several years beyond 2010. By excluding these drugs, far fewer negative UAFs are expected in future years.

Table 34 shows annual and cumulative allowed and actual expenditures for physicians' services from April 1, 1996, through the end of the current CY, including the short periods in 1999 when we transitioned to a CY system. As discussed in the CY 2010 PFS proposed rule (74 FR 33651), once the Secretary has revised the level of allowed expenditures during the base year (as is authorized under the statute), it is reasonable to carry this revision through into all subsequent years. Thus, Table 34 also reflects recomputed allowed and actual expenditures from the base year and subsequent years to remove the costs associated with physician-administered drugs.

Table 34 also shows the SGR corresponding with each period. The calculation of the SGR is discussed in detail below in this section.

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TABLE 34: Annual and Cumulative Allowed and Actual Expenditures for Physicians' Services from April 1, 1996 through the End of the Current Calendar Year

Period	Annual Allowed Expenditures ($ in billions)	Annual Actual Expenditures ($ in billions)	Cumulative Allowed Expenditures ($ in billions)	Cumulative Actual Expenditures ($ in billions)	FY/CY SGR
4/1/96-3/31/97	$46.8[1]	$46.8	$46.8	$46.8	N/A
4/1/97-3/31/98	$48.3	$47.0	$95.2	$93.9	FY 1998=3.2%
4/1/98-3/31/99	$50.4	$47.8	$145.6	$141.7	FY 1999=4.2%
1/1/99-3/31/99	$12.7	$12.4	(2)	$141.7	FY 1999=4.2%
4/1/99-12/31/99	$40.3	$37.0	(3)	$178.8	FY 2000=6.9%
1/1/99-12/31/99	$53.0	$49.5	$185.8	$178.8	FY 1999/2000
1/1/00-12/31/00	$56.8	$54.1	$242.7	$232.9	CY 2000=7.3%
1/1/01-12/31/01	$59.4	$61.2	$302.1	$294.2	CY 2001=4.5%
1/1/02-12/31/02	$64.3	$64.6	$366.4	$358.7	CY 2002=8.3%
1/1/03-12/31/03	$69.0	$70.2	$435.4	$429.0	CY 2003=7.3%
1/1/04-12/31/04	$73.6	$78.3	$509.0	$507.2	CY 2004=6.6%
1/1/05-12/31/05	$76.7	$83.5	$585.7	$590.7	CY 2005=4.2%
1/1/06-12/31/06	$77.8	$84.6	$663.5	$675.3	CY 2006=1.5%
1/1/07-12/31/07	$80.5	$84.5	$744.0	$759.8	CY 2007=3.5%
1/1/08-12/31/08	$84.2	$86.7	$828.2	$846.4	CY 2008=4.5%
1/1/09-12/31/09	$89.3	$90.5	$917.5	$936.9	CY 2009=6.1%
1/1/10-12/31/10	$81.4	NA	$998.9	NA	CY 2010=-8.8%

(1) Allowed expenditures in the first year (April 1, 1996-March 31, 1997) are equal to actual expenditures. All subsequent figures are equal to quarterly allowed expenditure figures increased by the applicable SGR. Cumulative allowed expenditures are equal to the sum of annual allowed expenditures. We provide more detailed quarterly allowed and actual expenditure data on our Web site at the following address: http://www.cms.hhs.gov/SustainableGRatesConFact/. We expect to update the web site with the most current information later this month.

(2) Allowed expenditures for the first quarter of 1999 are based on the FY 1999 SGR.

(3) Allowed expenditures for the last three quarters of 1999 are based on the FY 2000 SGR.

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Consistent with section 1848(d)(4)(E) of the Act, Table 34 includes our second revision of allowed expenditures for CY 2008, a recalculation of allowed expenditures for CY 2009, and our initial estimate of allowed expenditures for CY 2010. To determine the UAF for CY 2010, the statute requires that we use allowed and actual expenditures from April 1, 1996 through December 31, 2009 and the CY 2010 SGR. Consistent with section 1848(d)(4)(E) of the Act, we will be making revisions to the CY 2009 and CY 2010 SGRs and CY 2009 and CY 2010 allowed expenditures. Because we have incomplete actual expenditure data for CY 2009, we are using an estimate for this period. Any difference between current estimates and final figures will be taken into account in determining the UAF for future years. In addition, as discussed above, in order to effectuate fully the Secretary's policy decision to remove drugs from the definition of ''physicians' services,'' we are removing drugs from the calculation of allowed expenditures for CY 2010, CY 2009, CY 2008, and all prior years.

We are using figures from Table 34 in the following statutory formula:

$$UAF_{10} = \frac{Target_{09} - Actual_{09}}{Actual_{09}} \times 0.75 + \frac{Target_{4/96-12/09} - Actual_{4/96-12/09}}{Actual_{09} \times SGR_{10}} \times 0.33$$

UAF_{10} = Update Adjustment Factor for CY 2010 = −8.8 percent

$Target_{09}$ = Allowed Expenditures for CY 2009 = $89.3 billion

$Actual_{09}$ = Estimated Actual Expenditures for CY 2009 = $90.5 billion

$Target_{4/96-12/09}$ = Allowed Expenditures from 4/1/1996–12/31/2009 = $917.5 billion

$Actual_{4/96-12/09}$ = Estimated Actual Expenditures from 4/1/1996—12/31/2009 = $936.9 billion

SGR_{10} = −8.8 percent (0.912)

$$\frac{\$89.3 - \$90.5}{\$90.5} \times 0.75 + \frac{\$917.5 - \$936.9}{\$90.5 \times 0.912} \times 0.33 = -8.8\%$$

If we had not removed the costs associated with physician-administered drugs from the calculation of allowed and actual expenditures retrospectively to the 1996/1997 base year and from the calculation of the SGR beginning with 2010 SGR, the UAF determined using the statutory formula would have been −30.9 percent.

$$\frac{\$93.2 - \$100.8}{\$100.8} \times 0.75 + \frac{\$958.0 - \$1,029.8}{\$100.8 \times 0.930} \times 0.33 = -30.9\%$$

The increase in the UAF reflects the reduced discrepancy between actual and target expenditures resulting from removing the costs of physician-administered drugs from our calculations.

Section 1848(d)(4)(D) of the Act indicates that the UAF determined under section 1848(d)(4)(B) of the Act for a year may not be less than −0.07 or greater than 0.03. Since −0.088 is less than −0.07, the UAF for CY 2010 will be −0.07. Moreover, because −0.088 and −0.309 are both less than −0.07, removing the costs of physician-administered drugs from our calculations did not change the effective UAF for CY 2010.

Section 1848(d)(4)(A)(ii) of the Act indicates that 1.0 should be added to the UAF determined under section 1848(d)(4)(B) of the Act. Thus, adding 1.0 to −0.07 makes the UAF equal to 0.93.

Section 1848(d) of the Act provides that the PFS update is equal to the product of the MEI and the UAF. Because the effective UAF for CY 2010 is −0.07 whether or not the costs of physician-administered drugs are included in the levels of allowed and actual expenditures, removing these costs from our calculation did not change the physician payment update for services furnished on or after January 1, 2010.

VI. Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate

A. Medicare Sustainable Growth Rate

The SGR is an annual growth rate that applies to physicians' services paid by Medicare. The use of the SGR is intended to control growth in aggregate Medicare expenditures for physicians' services. Payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Rather, the PFS update, as specified in section 1848(d)(4) of the Act, is adjusted based on a comparison of allowed expenditures (determined using the SGR) and actual expenditures. If actual expenditures exceed allowed expenditures, the update is reduced. If actual expenditures are less than allowed expenditures, the update is increased.

Section 1848(f)(2) of the Act specifies that the SGR for a year (beginning with CY 2001) is equal to the product of the following four factors:

(1) The estimated change in fees for physicians' services;

(2) The estimated change in the average number of Medicare fee-for-service beneficiaries;

(3) The estimated projected growth in real GDP per capita; and

(4) The estimated change in expenditures due to changes in statute or regulations.

In general, section 1848(f)(3) of the Act requires us to publish SGRs for 3 different time periods, no later than November 1 of each year, using the best data available as of September 1 of each year. Under section 1848(f)(3)(C)(i) of the Act, the SGR is estimated and subsequently revised twice (beginning with the FY and CY 2000 SGRs) based on later data. (The Act also provides for adjustments to be made to the SGRs for FY 1998 and FY 1999. See the February 28, 2003 **Federal Register** (68 FR 9567)

for a discussion of these SGRs). Under section 1848(f)(3)(C)(ii) of the Act, there are no further revisions to the SGR once it has been estimated and subsequently revised in each of the 2 years following the preliminary estimate. In this final rule with comment, we are making our preliminary estimate of the CY 2010 SGR, a revision to the CY 2009 SGR, and our final revision to the CY 2008 SGR. Although we are removing drugs from the calculation of allowed and actual expenditures under sections 1848(d)(3)(C) and 1848(d)(4) of the Act retrospectively to the 1996/1997 base year, we determined that we are only authorized to remove drugs from the calculation of the SGR beginning with 2010. Therefore, we will not be removing drugs from previous years' SGR calculations, and the revisions to our estimates of the CY 2009 and CY 2008 SGRs will be limited to revisions to reflect later data available as of September 1, 2009, that were not available when we published our previous estimates.

B. Physicians' Services

Section 1848(f)(4)(A) of the Act defines the scope of physicians' services covered by the SGR. The statute indicates that ''the term physicians' services includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.''

We published a definition of physicians' services for use in the SGR in the November 1, 2001 **Federal Register** (66 FR 55316). We defined physicians' services to include many of the medical and other health services listed in section 1861(s) of the Act. As discussed in section VII.C. of this final rule with comment period, the statute provides the Secretary with clear discretion to decide whether physician-administered drugs should be included or excluded from the definition of ''physicians' services.'' Accordingly, we are finalizing our proposal to remove physician-administered drugs from the definition of ''physicians' services'' in section 1848(f)(4)(A) of the Act for purposes of computing the SGR and the levels of allowed expenditures and actual expenditures CY 2010 and all future years. Furthermore, in order to effectuate fully the Secretary's policy decision to remove drugs from the definition of ''physicians' services,'' we are removing physician-administered drugs from the calculation of allowed and actual expenditures for all prior years.

Thus, for purposes of determining allowed expenditures, actual expenditures for all years, and SGRs for CY 2010 and subsequent years, we are specifying that physicians' services include the following medical and other health services if bills for the items and services are processed and paid by Medicare carriers (and those paid through intermediaries where specified) or the equivalent services processed by the Medicare Administrative Contractors:

- Physicians' services.
- Services and supplies furnished incident to physicians' services, except for the expenditures for drugs and biologicals which are not usually self-administered by the patient.
- Outpatient physical therapy services and outpatient occupational therapy services.
- Services of PAs, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, clinical social workers, NPs, and certified nurse specialists.
- Screening tests for prostate cancer, colorectal cancer, and glaucoma.
- Screening mammography, screening pap smears, and screening pelvic exams.
- Diabetes outpatient self-management training (DSMT) services.
- MNT services.
- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests (including outpatient diagnostic laboratory tests paid through intermediaries).
- X-ray, radium, and radioactive isotope therapy.
- Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations.
- Bone mass measurements.
- An initial preventive physical exam.
- Cardiovascular screening blood tests.
- Diabetes screening tests.
- Telehealth services.
- Physician work and resources to establish and document the need for a power mobility device.

C. Preliminary Estimate of the SGR for 2010

Our preliminary estimate of the CY 2010 SGR is −8.8 percent. We first estimated the CY 2010 SGR in March 2009, and we made the estimate available to the MedPAC and on our Web site. Table 35 shows the March 2009 estimate and our current estimates of the factors included in the CY 2010 SGR.

TABLE 35—2010 SGR CALCULATION

Statutory factors	March estimate	Current estimate
Fees	1.2 percent (1.012)	0.9 percent (1.009)
Enrollment	−0.3 percent (0.997)	1.2 percent (1.012)
Real Per Capita GDP	0.8 percent (1.008)	0.7 percent (1.007)
Law and Regulation	−9.7 percent (0.903)	−11.3 percent (0.887)
Total	−8.2 percent (0.918)	−8.8 percent (0.912)

Note: Consistent with section 1848(f)(2) of the Act, the statutory factors are multiplied, not added, to produce the total (that is, 1.009 × 1.012 × 1.007 × 0.887 = 0.912). A more detailed explanation of each figure is provided in section VIII.F.1 of this preamble.

D. Revised Sustainable Growth Rate for 2009

Our current estimate of the CY 2009 SGR is 6.1 percent. Table 36 shows our preliminary estimate of the CY 2009 SGR that was published in the CY 2009 PFS final rule with comment period (73 FR 69904) and our current estimate.

TABLE 36—2009 SGR CALCULATION

Statutory factors	Estimate from CY 2009 final rule	Current estimate
Fees	2.1 percent (1.021)	1.8 percent (1.018)
Enrollment	−0.2 percent (0.998)	−0.8 percent (0.992)
Real Per Capita GDP	1.2 percent (1.012)	0.9 percent (1.009)
Law and Regulation	4.2 percent (1.042)	4.1 percent (1.041)
Total	7.4 percent (1.074)	6.1 percent (1.061)

A more detailed explanation of each figure is provided in section VIII.F.2 of this preamble.

E. Final Sustainable Growth Rate for 2008

The SGR for 2008 is 4.5 percent. Table 37 shows our preliminary estimate of the 2008 SGR from the CY 2008 PFS final rule with comment period (72 FR 66379), our revised estimate from the CY 2009 PFS final rule with comment period (73 FR 69904) and the final figures determined using the best available data as of September 1, 2009.

TABLE 37—2008 SGR CALCULATION

Statutory factors	Estimate from CY 2008 final rule	Estimate from CY 2009 final rule	Final
Fees	1.9 percent (1.019)	1.4 percent (1.014)	1.4 percent (1.014).
Enrollment	−0.7 percent (0.993)	−3.2 percent (0.968)	−2.0 percent (0.980).
Real Per Capita GDP	1.7 percent (1.017)	1.6 percent (1.016)	1.6 percent (1.016).
Law and Regulation	−2.9 percent (0.971)	3.5 percent (1.035)	3.5 percent (1.035).
Total	−0.1 percent (0.999)	3.2 percent (1.032)	4.5 percent (1.045).

A more detailed explanation of each figure is provided in section VIII.F.3. of this final rule.

F. Calculation of 2010, 2009, and 2008 Sustainable Growth Rates

1. Detail on the CY 2010 SGR

All of the figures used to determine the CY 2010 SGR are estimates that will be revised based on subsequent data. Any differences between these estimates and the actual measurement of these figures will be included in future revisions of the SGR and allowed expenditures and incorporated into subsequent PFS updates.

• *Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2010*

This factor is calculated as a weighted-average of the CY 2010 changes in fees for the different types of services included in the definition of physicians' services for the SGR. Medical and other health services paid using the PFS are estimated to account for approximately 90.8 percent of total allowed charges included in the SGR in CY 2010 and are updated using the MEI. The MEI for CY 2010 is 1.2 percent. Diagnostic laboratory tests are estimated to represent approximately 9.2 percent of Medicare allowed charges included in the SGR for CY 2010. Medicare payments for these tests are updated by the Consumer Price Index for Urban Areas (CPI–U), which is −1.4 percent for CY 2010. However, section 145 of the MIPPA reduces the update applied to clinical laboratory tests by 0.5 percent for CY 2009 through CY 2013. Therefore, for CY 2010, diagnostic laboratory tests will receive an update of −1.9 percent. As noted in Section VII.C. of this final rule with comment period, we are finalizing our proposal to remove physician-administered drugs from the allowed charges included in the SGR in CY 2010 and in all future years. Therefore, drugs represent 0.0 percent of Medicare allowed charges included in the SGR in CY 2010.

Table 38 shows the weighted-average of the MEI and laboratory price changes for CY 2010.

TABLE 38—WEIGHTED-AVERAGE OF THE MEI AND LABORATORY PRICE CHANGES FOR CY 2010

	Weight	Update
Physician	0.908	1.2
Laboratory	0.092	−1.9
Weighted-average	1.000	0.9

We estimate that the weighted-average increase in fees for physicians' services in CY 2010 under the SGR (before applying any legislative adjustments) will be 0.9 percent.

• *Factor 2—The Percentage Change in the Average Number of Part B Enrollees from CY 2009 to CY 2010*

This factor is our estimate of the percent change in the average number of fee-for-service enrollees from CY 2009 to CY 2010. Services provided to Medicare Advantage (MA) plan enrollees are outside the scope of the SGR and are excluded from this estimate. We estimate that the average number of Medicare Part B fee-for-service enrollees will increase by 1.2 percent from CY 2009 to CY 2010. Table 39 illustrates how this figure was determined.

TABLE 39—AVERAGE NUMBER OF MEDICARE PART B FEE-FOR-SERVICE ENROLLEES FROM CY 2009 TO CY 2010

[Excluding beneficiaries enrolled in MA plans]

	2009	2010
Overall	42.431 million	43.164 million.
Medicare Advantage (MA)	10.926 million	11.271 million.
Net	31.506 million	31.893 million.

TABLE 39—AVERAGE NUMBER OF MEDICARE PART B FEE-FOR-SERVICE ENROLLEES FROM CY 2009 TO CY 2010—Continued

[Excluding beneficiaries enrolled in MA plans]

	2009	2010
Percent Increase		1.2 percent.

An important factor affecting fee-for-service enrollment is beneficiary enrollment in MA plans. Because it is difficult to estimate the size of the MA enrollee population before the start of a CY, at this time we do not know how actual enrollment in MA plans will compare to current estimates. For this reason, the estimate may change substantially as actual Medicare fee-for-service enrollment for CY 2010 becomes known.

• *Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2010*

We estimate that the growth in real GDP per capita from CY 2009 to CY 2010 will be 0.7 percent (based on the 10-year average GDP over the 10 years of 2001 through 2010). Our past experience indicates that there have also been changes in estimates of real per capita GDP growth made before the year begins and the actual change in GDP computed after the year is complete. Thus, it is possible that this figure will change as actual information on economic performance becomes available to us in 2010.

• *Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2010 Compared With CY 2009*

The statutory and regulatory provisions that will affect expenditures in CY 2010 relative to CY 2009 are estimated to have an impact on expenditures of −11.3 percent. These include the MIPPA provisions regarding the physician update, e-prescribing bonuses, the expiration of the work GPCI floor, and the expiration of payment provisions related to certain pathology services.

2. Detail on the 2009 SGR

A more detailed discussion of our revised estimates of the four elements of the 2009 SGR follows.

• *Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2009*

This factor was calculated as a weighted-average of the 2009 changes in fees that apply for the different types of services included in the definition of physicians' services for the SGR in 2009.

We estimate that services paid using the PFS account for approximately 82.4 percent of total allowed charges included in the SGR in CY 2009. These services were updated using the CY 2009 MEI of 1.6 percent. We estimate that diagnostic laboratory tests represent approximately 8.0 percent of total allowed charges included in the SGR in CY 2009. Medicare payments for these tests are updated by the CPI–U, which is 5.0 percent for CY 2009. However, section 145 of the MIPPA reduces the update applied to clinical laboratory tests by 0.5 percent for CY 2009 through CY 2013. Therefore, for CY 2009, diagnostic laboratory tests will receive an update of 4.5 percent. We estimate that drugs represent 9.7 percent of Medicare-allowed charges included in the SGR in CY 2009. We estimate a weighted-average change in fees for drugs included in the SGR (using the ASP+6 percent pricing method) of 1.6 percent for CY 2009.

Table 40 shows the weighted-average of the MEI, laboratory, and drug price changes for CY 2009.

TABLE 40—WEIGHTED-AVERAGE OF THE MEI, LABORATORY, AND DRUG PRICE CHANGES FOR CY 2009

	Weight	Update
Physician	0.824	1.6
Laboratory	0.080	4.5
Drugs	0.097	1.6
Weighted-average	1.000	1.8

After considering the elements described in Table 40, we estimate that the weighted-average increase in fees for physicians' services in 2009 under the SGR (before applying any legislative adjustments) will be 1.8 percent. Our estimate of this factor in the CY 2009 PFS final rule with comment period was 2.1 percent (73 FR 69905). The decrease in the estimate is due to the availability of some actual data.

• *Factor 2—The Percentage Change in the Average Number of Part B Enrollees from CY 2008 to CY 2009*

We estimate that the average number of Medicare Part B fee-for-service enrollees (excluding beneficiaries enrolled in Medicare Advantage plans) decreased by 0.8 percent in CY 2009. Table 41 illustrates how we determined this figure.

TABLE 41—AVERAGE NUMBER OF MEDICARE PART B FEE-FOR-SERVICE ENROLLEES FROM CY 2008 TO CY 2009

[Excluding beneficiaries enrolled in MA plans]

	2008	2009
Overall	41.747 million	42.431 million.
Medicare Advantage (MA)	9.999 million	10.926 million.
Net	31.748 million	31.506 million.
Percent Increase		− 0.8 percent.

Our estimate of the − 0.8 percent change in the number of fee-for-service enrollees, net of Medicare Advantage enrollment for CY 2009 compared to CY 2008, is a larger change than our original estimate of − 0.2 percent in the CY 2009 PFS final rule with comment period (73 FR 69905). While our current projection based on data from 8 months of 2009 differs from our original estimate of − 0.2 percent when we had no actual data, it is still possible that our final estimate of this figure will be different once we have complete information on CY 2009 fee-for-service enrollment.

• *Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in CY 2009*

We estimate that the growth in real GDP per capita will be 0.9 percent for

CY 2009 (based on the 10-year average GDP over the 10 years of CY 2000 through CY 2009). Our past experience indicates that there have also been differences between our estimates of real per capita GDP growth made prior to the year's end and the actual change in this factor. Thus, it is possible that this figure will change further as complete actual information on CY 2009 economic performance becomes available to us in 2010.

• *Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2009 Compared With CY 2008*

The statutory and regulatory provisions that will affect expenditures in CY 2009 relative to CY 2008 are estimated to have an impact on expenditures of 4.1 percent. These include the DRA provision reducing payments for imaging services, the MMSEA provision regarding the PQRI bonuses payable in 2009, and the MIPPA provisions regarding the change in cost sharing for mental health services, the physician update, and the change in application of BN to the CF.

3. Detail on the CY 2008 SGR

A more detailed discussion of our final revised estimates of the four elements of the CY 2008 SGR follows.

• *Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2008*

This factor was calculated as a weighted-average of the CY 2008 changes in fees that apply for the different types of services included in the definition of physicians' services for the SGR in 2008.

Services paid using the PFS accounted for approximately 82.7 percent of total Medicare-allowed charges included in the SGR for CY 2008 and are updated using the MEI. The MEI for CY 2008 was 1.8 percent. Diagnostic laboratory tests represented approximately 7.7 percent of total CY 2008 Medicare allowed charges included in the SGR and are updated by the CPI–U. However, section 628 of the MMA specifies that diagnostic laboratory tests will receive an update of 0.0 percent from CY 2004 through CY 2008. Drugs represented approximately 9.7 percent of total Medicare-allowed charges included in the SGR for CY 2008. We estimate a weighted-average change in fees for drugs included in the SGR of − 0.7 percent for 2007. Table 42 shows the weighted-average of the MEI, laboratory, and drug price changes for CY 2008.

TABLE 42—WEIGHTED-AVERAGE OF THE MEI, LABORATORY, AND DRUG PRICE CHANGES FOR CY 2008

	Weight	Update
Physician	0.827	1.8
Laboratory	0.077	0.0
Drugs	0.097	− 0.7
Weighted-average	1.000	1.4

After considering the elements described in Table 42, we estimate that the weighted-average increase in fees for physicians' services in CY 2008 under the SGR (before applying any legislative adjustments) was 1.4 percent. This figure is a final one based on complete data for CY 2008.

• *Factor 2—The Percentage Change in the Average Number of Part B Enrollees from CY 2008 to CY 2007*

We estimate the decrease in the number of fee-for-service enrollees (excluding beneficiaries enrolled in MA plans) from CY 2007 to CY 2008 was − 2.0 percent. Our calculation of this factor is based on complete data from CY 2008. Table 43 illustrates the calculation of this factor.

TABLE 43—AVERAGE NUMBER OF MEDICARE PART B FROM CY 2007 TO CY 2008

[Excluding beneficiaries enrolled in MA plans]

	2007	2008
Overall	41.055 million	41.747 million.
Medicare Advantage (MA)	8.661 million	9.999 million.
Net	32.394 million	31.748 million.
Percent Increase		− 2.0 percent.

• *Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2008*

We estimate that the growth in real per capita GDP was 1.6 percent in 2008 (based on the 10-year average GDP over the 10 years of CY 1999 through CY 2008). This figure is a final one based on complete data for CY 2008.

• *Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2008 Compared With CY 2007*

Our final estimate for the net impact on expenditures from the statutory and regulatory provisions that affect expenditures in CY 2008 relative to CY 2007 is 3.5 percent. These include the DRA provision reducing payments for imaging services, the MIEA TRHCA provisions regarding the 2007 PQRI reporting bonuses payable in 2008, and the MIPPA provisions regarding the physician update and bonus payments for mental health services.

VII. Anesthesia and Physician Fee Schedule Conversion Factors for CY 2010

The CY 2010 PFS CF is $28.4061. The CY 2010 national average anesthesia CF is $16.6191.

A. Physician Fee Schedule Conversion Factor

The PFS CF for a year is calculated in accordance with section 1848(d)(1)(A) of the Act by multiplying the previous year's CF by the PFS update. The formula for calculating the PFS update is set forth in section 1848(d)(4)(A) of the Act. In general, the PFS update is determined by multiplying the CF for the previous year by the percentage increase in the MEI times the UAF, which is calculated as specified under section 1848(d)(4)(B) of the Act. However, Section 101 of the MIEA–TRHCA provided a 1-year increase in the CY 2007 CF and specified that the CF for CY 2008 must be computed as if the 1-year increase had never applied. Section 101 of the MMSEA provided a 6-month increase in the CY 2008 CF, from January 1, 2008, through June 30, 2008, and specified that the CF for the remaining portion of 2008 and the CFs for CY 2009 and subsequent years must be computed as if the 6-month increase had never applied. Section 131 of the MIPPA extended the increase in the CY 2008 CF that applied during the first half of the year to the entire year, provided for a 1.1 percent increase to the CY 2009 CF, and specified that the CFs for CY 2010 and subsequent years must be computed as if the increases for

CYs 2007, 2008, and 2009 had never applied.

In order to determine the 2010 PFS CF update, the CFs for 2007, 2008, and 2009 must be calculated as if the various legislative changes to the CFs for those years had not occurred.

Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ more than $20 million from what would have been in the absence of these changes. If this threshold is exceeded, we must make adjustments to preserve BN. We estimate that CY 2010 RVU changes would result in a decrease in Medicare physician expenditures of more than $20 million. Therefore, we are increasing the CF by 1.00103 to offset this estimated decrease in Medicare physician expenditures due to the CY 2010 RVU changes.

We illustrate the calculation of the CY 2010 PFS CF in Table 44.

TABLE 44: Calculation of the CY 2010 PFS CF

CY 2006 Conversion Factor		$37.8975
CY 2007 Pre-legislation Conversion Factor Update	-5.0 percent (0.94953)	
CY 2007 Pre-legislation Conversion Factor		$35.9848
CY 2008 Pre-legislation Conversion Factor Update	-5.3 percent (0.94674)	
CY 2008 Pre-legislation Conversion Factor		$34.0682
CY 2009 Pre-legislation total, including budget neutrality adjustments totaling -6.3 percent	-11.5 percent (0.88502)	
CY 2009 Pre-legislation Conversion Factor		$30.1510
CY 2010 Medicare Economic Index	1.2 percent (1.012)	
CY 2010 Update Adjustment Factor	-7.0 percent (0.930)	
CY 2010 CF Budget Neutrality Adjustment	0.103 percent (1.00103)	
CY 2010 Conversion Factor		**$28.4061**

Payment for services under the PFS will be calculated as follows:

Payment = [(RVU work × GPCI work) + (RVU PE × GPCI PE) + (RVU malpractice × GPCI malpractice)] × CF.

B. Anesthesia Conversion Factor

We calculate the anesthesia CF as indicated in Table 45. Anesthesia services do not have RVUs like other PFS services. Therefore, we account for any necessay RVU adjustments through an adjustment tothe anesthesia CF to simulate changes to RVUs. More specifically, if there is an adjustment to thework, PE, or malpractice RVUs, these adjustments are applied to the respective shares of the anesthesia CF as these shares are proxies for the work, PE, and malpractice RVUs for anesthesia services.

As explained above, section 101 of the MIEA–TRHCA provided a 1-year increase in the CY 2007 CF and specified that the CF for CY 2008 must be computed as if the 1-year increase had never applied. Section 101 of the MMSEA provided a 6-month increase in the CY 2008 CF, from January 1, 2008, through June 30, 2008, and specified that the CF for the remaining portion of 2008 and the CFs for CY 2009 and subsequent years must be computed as if the 6-month increase had never applied. Section 131 of the MIPPA extended the increase in the CY 2008 CF from the first half of the year to the entire year, provided for a 1.1 percent increase to the CY 2009 CF, and specified that the CFs for CY 2010 and subsequent years must be computed as if the increases for CYs 2007, 2008, and 2009 had never applied.

In order to determine the 2010 PFS CF update, the CFs for 2007, 2008, and 2009 must be calculated as if the various legislative changes to the CFs for those years had not occurred. Also, section 133(b) of the MIPPA provided for the application of the 2007–2008 5-Year work review BN adjuster to the CF for years beginning with 2009. To make this change for the anesthesia CF, we recalculated the adjustments to the anesthesia CF for CY 2007 and CY 2008 by removing the BN adjuster for work which had been applied to calculate the CF for each of these years. (See the CY 2009 PFS final rule with comment period (73 FR 69909) for more information on this calculation.) Table 45 also includes the CY 2010 adjustment to the anesthesia CF due to changes in CY 2010 payment polices for PE and malpractice RVUs.

TABLE 45: Calculation of the CY 2010 Anesthesia Conversion Factor

CY 2006 Anesthesia Conversion Factor		$17.7663
CY 2007 Pre-legislation Conversion Factor Update	-5.0 percent (0.94953)	
CY 2007 Adjustment without BN adjuster	.9874	
CY 2007 Pre-legislation Conversion Factor		$16.6571
CY 2008 Pre-legislation Conversion Factor Update	-5.3 percent (0.94674)	
CY 2008 Adjustment without BN adjuster	1.2528	
CY 2008 Pre-legislation Conversion Factor		$19.7566
CY 2009 Pre-legislation total, including budget neutrality adjustments totaling -6.3 percent	-11.5 percent (0.88502)	
CY 2009 Pre-legislation Conversion Factor		$17.4849
CY 2010 Medicare Economic Index	1.2 percent (1.012)	
CY 2010 Update Adjustment Factor	-7.0 percent (0.930)	
CY 2010 Anesthesia Adjustment	0.99 percent (1.0099)	
CY 2010 Anesthesia Conversion Factor		**$16.6191**

VIII. Telehealth Originating Site Facility Fee Payment Amount Update

Section 1834(m) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act. The MEI increase for 2010 is 1.2 percent.

Therefore, for CY 2010, the payment amount for HCPCS code Q3014, Telehealth originating site facility fee, is 80 percent of the lesser of the actual charge or $24.00. The Medicare telehealth originating site facility fee and MEI increase by the applicable time period is shown in Table 46.

TABLE 46: The Medicare Telehealth Originating Site Facility Fee and MEI Increase by the Applicable Time Period

Facility Fee	MEI Increase	Period
$20.00	N/A	10/01/2001 – 12/31/2002
$20.60	3.0%	01/01/2003 – 12/31/2003
$21.20	2.9%	01/01/2004 – 12/31/2004
$21.86	3.1%	01/01/2005 – 12/31/2005
$22.47	2.8%	01/01/2006 – 12/31/2006
$22.94	2.1%	01/01/2007 – 12/31/2007
$23.35	1.8%	01/01/2008 – 12/31/2008
$23.72	1.6%	01/01/2009 – 12/31/2009
$24.00	1.2%	01/01/2010 – 12/31/2010

IX. Provisions of the Final Rule

The provisions of this final rule with comment period restate the provisions of the CY 2010 PFS proposed rule, except as noted elsewhere in the preamble.

X. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on

the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

We utilize HCPCS codes for Medicare payment purposes. The HCPCS is a national drug coding system comprised of Level I (CPT) codes and Level II (HCPCS National Codes) that are intended to provide uniformity to coding procedures, services, and supplies across all types of medical providers and suppliers. Level I (CPT) codes are copyrighted by the AMA and consist of several categories, including Category I codes which are 5-digit numeric codes, and Category III codes which are temporary codes to track emerging technology, services, and procedures.

The AMA issues an annual update of the CPT code set each Fall, with January 1 as the effective date for implementing the updated CPT codes. The HCPCS, including both Level I and Level II codes, is similarly updated annually on a CY basis. Annual coding changes are not available to the public until the Fall immediately preceding the annual January update of the PFS. Because of the timing of the release of these new codes, it is impracticable for CMS to provide prior notice and solicit comment on these codes and the RVUs assigned to them in advance of publication of the final rule that implements the PFS. Yet, it is imperative that these coding changes be accounted for and recognized timely under the PFS for payment because services represented by these codes will be provided to Medicare beneficiaries by physicians during the CY in which they become effective. Moreover, regulations implementing HIPAA (42 CFR parts 160 and 162) require that the HCPCS be used to report health care services, including services paid under the PFS. We also assign interim RVUs to any new codes based on a review of the RUC recommendations for valuing these services. By reviewing these RUC recommendations for the new codes, we are able to assign RVUs to services based on input from the medical community and to establish payment for them, on an interim basis, that corresponds to the relative resources associated with furnishing the services. If we did not assign RVUs to new codes on an interim basis, the alternative would be to either not pay for these services during the initial CY or have each carrier establish a payment rate for these new codes. We believe both of these alternatives are contrary to the public interest, particularly since the RUC process allows for an assessment of the valuation of these services by the medical community prior to our establishing payment for these codes on an interim basis. Therefore, we believe it would be contrary to the public interest to delay establishment of fee schedule payment amounts for these codes.

For the reasons outlined above in this section, we find good cause to waive the notice of proposed rulemaking for the interim RVUs for selected procedure codes identified in Addendum C and to establish RVUs for these codes on an interim final basis. We are providing a 60-day public comment period.

Section II.F. of this final rule with comment period discusses the identification and review of potentially misvalued codes by a workgroup of the AMA RUC, as well as our review and decisions regarding the AMA RUC workgroup's recommendations. Similar to the AMA RUC recommendations for new and revised codes discussed above, due to the timing of the AMA RUC workgroup's recommendations for the potentially misvalued codes, it was impracticable for CMS to solicit public comment regarding specific proposals for revision prior to this final rule with comment period. We believe it is in the public interest to implement the revised RVUs for the codes that were identified as misvalued, and that have been reviewed and re-evaluated by the AMA RUC workgroup, on an interim final basis for CY 2010. The revisions of RVUs for these codes will establish a more appropriate payment that better corresponds to the relative resources associated with furnishing these services. A delay in implementing revised values for these misvalued codes would not only perpetuate the known misvaluation for these services, it would also perpetuate a distortion in the payment for other services under the PFS. Implementing the changes now allows for a more equitable distribution of payments across all PFS services. We believe a delay in implementation of these revisions would be contrary to the public interest, particularly since the AMA RUC process allows for an assessment of the valuation of these services by the medical community prior to the AMA RUC's recommendation to CMS. For the reasons described above, we find good cause to waive notice and comment procedures with respect to the misvalued codes identified in Table 5, and to revise RVUs for these codes on an interim final basis. We are providing a 60-day public comment period.

We ordinarily provide a 60-day delay in the effective date of the provisions of a rule in accordance with the Administrative Procedure Act (APA) (5 U.S.C. 553(d)), which requires a 30-day delayed effective date, and the Congressional Review Act (5 U.S.C. 801(a)(3)), which requires a 60-day delayed effective date for major rules. However, we can waive the delay in the effective date if the Secretary finds, for good cause, that the delay is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons in the rule issued (5 U.S.C. 553(d)(3); 5 U.S.C. 808(2)).

In section II. G. 6 of this final rule with comment period, we are finalizing our proposed criteria for designating organizations to accredit suppliers furnishing the TC of advanced diagnostic imaging services as specified in section 1834(e) of the Act. We also discuss our expectation to publish a notice the same day that this final rule is issued to solicit applications from entities for the purpose of becoming a designated accreditation organization. We note that section 1834(e) of the Act requires us to designate organizations to accredit suppliers furnishing the TC of advanced diagnostic imaging services by January 1, 2010. Given the statutory deadline to designate organizations and the timing of the publication of this final rule with comment period, we believe it is impracticable to delay the effective date of these criteria for designating organizations to accredit suppliers furnishing the TC of advanced diagnostic imaging services. Therefore, we believe that we have good cause for making the imaging accreditation provisions effective upon publication.

XI. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs Regarding Pulmonary Rehabilitation Program: Conditions for Coverage (§ 410.47)

Section 410.47(c) lists the components of a pulmonary rehabilitation program. Specifically, § 410.47(c)(3) through (c)(5) discuss psychosocial assessments, outcome assessments and individualized treatment plans, respectively, and the role of these tools in pulmonary rehabilitation programs. The burden associated with meeting the requirements for conducting psychosocial assessments, outcome assessments, and individualized treatment plans is the time and effort necessary for providers to document the necessary information in the patient record. While these requirements are subject the PRA, we believe the associated burden is exempt as stated under 5 CFR 1320.3(b)(2). Psychosocial assessments, outcome assessments and individualized treatment plans are routine tools used in pulmonary rehabilitation programs and the practice of using these tools is generally recognized as an industry standard as part of usual and customary business practices.

B. ICRs Regarding Kidney Disease Education Services (§ 410.48)

Section 410.48(f) states qualified persons will develop outcomes assessments designed to:

- Measure beneficiary knowledge about chronic kidney disease (CKD) and its treatment;
- Assess program effectiveness of preparing the beneficiary to make informed decisions about their healthcare options related to CKD; and
- Assess program effectiveness in meeting the communication needs of underserved populations, including persons with disabilities, persons with limited English proficiency, and persons with health literacy needs.

The assessment will be administered to the beneficiary during one of the kidney disease education (KDE) sessions prescribed by the referring physician. The assessments will be made available to CMS upon request.

The burden associated with these requirements is the time and effort necessary to conduct an outcomes assessment, maintain record of the assessment, and to make the documentation available to CMS upon request. At this time, we are not able to accurately quantify the burden because we cannot estimate the number of entities that must comply with these requirements. Additionally, we are trying to determine if the use and maintenance of outcome assessments in KDE services is a standard industry business practice. Our preliminary research gathered during a CMS Open Door Forum held on November 6, 2008 and a stakeholders meeting hosted by the Agency for Healthcare Research and Quality (AHRQ) on December 16, 2008 indicates that outcome assessments are used by most but not all of the entities bound by the requirements in § 410.48. We solicited comments pertaining to this issue in the proposed rule that published July 13, 2009 (74 FR 33520); however, we did not receive any information to assist us in accurately quantifying the number of entities that must comply with this requirement. We will continue to evaluate the issue. If we find that the number of affected entities approaches the threshold of 10 as specified in 5 CFR 1320.3(c)(4), we will submit an information collection request to OMB for review and approval.

C. ICRs Regarding Cardiac Rehabilitation Program and Intensive Cardiac Rehabilitation Program: Conditions of Coverage (§ 410.49)

Section 410.49(b)(2) lists the required components of a cardiac rehabilitation program. Four of the five required components, including cardiac risk factor modification, psychosocial assessments, outcomes assessments and individualized treatment plans, impose information collection burdens. The burden associated with these requirements is the time and effort necessary to providers to customize each patient's cardiac risk modification program. Additionally, there is burden associated with conducting psychosocial assessments and outcome assessments and drafting individualized treatment plans. Although section 144(a) of the MIPPA sets forth these information collection requirements, we believe the associated information collection burden is exempt as stated under 5 CFR 1320.3(b)(2). Performing cardiac risk modification, psychosocial assessments, outcome assessments, and individualized treatment plans are routine tools used in cardiac rehabilitation programs. As stated earlier in the preamble of this final rule with comment period, intensive cardiac rehabilitation programs typically involve the same elements as general cardiac rehabilitation programs, but are furnished in highly structured environments in which sessions of the various components may be combined for longer periods of cardiac rehabilitation and also may be more rigorous. The ICRs and associated burden are generally recognized as an industry standard as part of usual and customary business practices.

Section 410.49(c)(1) states that to be approved as an intensive cardiac rehabilitation program, a program in an approved setting must be approved through the national coverage determination (NCD) process which may be generated internally by CMS or requested by a non-CMS entity. To be approved as an intensive cardiac rehabilitation program, the program must demonstrate through peer-reviewed, published research that it accomplishes one or more of the requirements listed in § 410.49(c)(1)(i) through (iii), as well as statistically significant reductions in 5 or more of the measures listed in § 410.49(c)(2)(i) through (vi). As described in § 410.49(c)(4), all prospective intensive cardiac rehabilitation sites must apply to enroll as an intensive cardiac rehabilitation program site using the designated forms as specified at § 424.510.

The burden associated with the requirements in § 410.49(c) is the time and effort necessary for a program to demonstrate through peer-reviewed, published research that it accomplishes one or more of the requirements listed in § 410.49(c)(1)(i) through (iii), as well as statistically significant reductions in 5 or more of the measures listed in § 410.49(c)(2)(i) through (vi) and the time and effort necessary for intensive cardiac rehabilitation sites to apply to enroll using the designated forms as specified at 424.510. At this time, we are not able to accurately quantify the burden because we cannot estimate the number of entities that will seek approval as intensive cardiac rehabilitation programs. We solicited comments pertaining to this issue in the CY 2010 PFS proposed rule (74 FR 33520); however, we did not receive any information to assist us in accurately quantifying the number of entities that must comply with this requirement. We will continue to evaluate the issue. If we find that the number of affected entities

approaches the threshold of 10 as specified in 5 CFR 1320.3(c)(4), we will submit an information collection request to OMB for review and approval.

D. ICRs Regarding Imaging Accreditation (§ 414.68)

Section 414.68(b) contains the application and reapplication procedures for accreditation organizations. Specifically, an independent accreditation organization applying for approval or reapproval of authority to survey suppliers for purposes of accrediting suppliers furnishing the technical component (TC) of advanced diagnostic imaging services must furnish CMS with all of the information listed in § 414.68(b)(1) through (14). The requirements include but are not limited to reporting, notification, documentation, and survey requirements.

The burden associated with the collection requirements in § 414.68(b) is the time and effort necessary to develop, compile and submit the information listed in § 414.68(b)(1) through (14). We believe that 3 entities will choose to comply with these requirements. We estimate that it will take each of the 3 entities, 80 hours to submit a complete application for approval or reapproval authority to become an accrediting organization approved by CMS.

Section 414.68(c) contains the information collection requirements pertaining to CMS approved accrediting organizations. An accrediting organization approved by CMS must undertake all of the activities listed in § 414.68(c)(1) through (6). The burden associated with the collection requirements in § 414.68(c) is the time and effort necessary to develop, compile and submit the information listed in § 414.68(c)(1) through (6). We believe that 3 entities will choose to comply with these requirements. We estimate that it will take each of the 3 entities, 80 hours to submit the required information on an ongoing basis.

For the aforementioned requirements in § 414.68(b) and § 414.68(c), we are aware that the potential respondent universe is greater than 10 entities; however, at this time, there are only three entities committed to the program. If the number of respondents approaches the threshold of 10 or more persons as defined in 5 CFR 1320.3(c)(4), we will develop and submit an information collection request to OMB for review and approval.

Section 414.68(d)(1) states that CMS or our contractor may conduct an audit of an accredited supplier, examine the results of a CMS-approved accreditation organization's survey of a supplier, or observe a CMS-approved accreditation organization's onsite survey of a supplier, in order to validate the CMS-approved accreditation organizations accreditation process. The burden associated with this requirement is the time and effort necessary for an accrediting organization to comply with the components of the validation audit. While this requirement is subject to the PRA, we believe the associated burden is exempt as stated in 5 CFR 1320.3(h)(6). The burden associated with a request for facts addressed to a single person, as defined in 5 CFR 1320.3(j), is not subject to the PRA.

As stated in § 414.68(e)(1), an accreditation organization dissatisfied with a determination that its accreditation requirements do not provide or do not continue to provide reasonable assurance that the suppliers accredited by the organization meet the applicable quality standards is entitled to a reconsideration. CMS reconsiders any determination to deny, remove, or not to renew the approval of deeming authority to an accreditation organization if the accrediting organization files a written request for reconsideration by our authorized officials or through its legal representative. The written request must be filed within 30 calendar days of the receipt of CMS' notice of an adverse determination or nonrenewal. In addition, the request must also specify the findings or issues with which the accreditation organization disagrees and the reasons for the disagreement.

The burden associated with this requirement is the time and effort necessary for an accrediting organization to develop and file a written request for reconsideration. While this requirement is subject to the PRA, the associated burden is exempt under 5 CFR 1320.4. The information in question is being collected as a result of an administrative action; accrediting organizations are submitting requests for reconsideration after receiving a notice of an adverse determination or nonrenewal.

E. ICRs Regarding Payment Rules (§ 414.408)

Section 414.408(j)(5) contains the notification requirements for suppliers electing to become grandfathered suppliers. Specifically, § 414.408(j)(5)(i) states that a noncontract supplier that elects to become a grandfathered supplier must provide a 30-day written notification to each Medicare beneficiary that resides in a competitive bidding area and is currently renting a competitively bid item from that supplier. The 30-day notification to the beneficiary must meet the requirements as listed in § 414.408(j)(5)(i)(A) through (G).

Subsequent to the initial 30-day notice to the beneficiary, as required by § 414.408(j)(5)(ii), suppliers must also obtain and maintain a record of the beneficiary's election choice, the date the choice was made, and the manner through which the beneficiary communicated his or her choice. Additionally, § 414.408(j)(5)(iii) states that if a beneficiary chooses not to continue to receive a grandfathered item(s) from his or her current supplier, the supplier must provide the beneficiary with two more notices prior to the supplier picking up its equipment. The supplier must provide a 10-day notification and a 2-day notification. These notification requirements must meet the criteria listed in § 414.408(j)(5)(iii)(A) though (C).

Section § 414.408(j)(5)(iv) requires suppliers that elect to become grandfathered suppliers to provide a written notification to CMS of its election decision. The notification must meet the requirements as specified in § 414.408(j)(5)(iv)(A) through (D).

The burden associated with the information collection requirements contained in § 414.408(j)(5) is the time and effort necessary for a noncontract supplier to make the aforementioned notifications to both beneficiaries and CMS. We estimate that 1,305 suppliers will elect to become grandfathered suppliers. Similarly, we estimate that each grandfathered supplier will need to make an average of 53 notifications based on an average of 52 beneficiaries per supplier and one notice to CMS. We estimate that it will take 2 hours to develop the notification to the beneficiary and 2 hours to develop the notification to CMS. Similarly, we estimate that each notification will take 15 minutes to send. The total estimated burden associated with each of the 1305 suppliers complying with the requirements in § 414.408(j)(5) is 17.25 hours per supplier for a total of 22,511 hours.

Section 414.408(j)(6) contains the information collection requirements pertaining to suppliers that choose not to become grandfathered suppliers. A noncontract supplier that elects not to become a grandfathered supplier is required to pick up the item it is currently renting to the beneficiary from the beneficiary's home after proper notification. Proper notification includes a 30-day, a 10-day, and a 2-day notice of the supplier's decision not to

become a grandfathered supplier to its Medicare beneficiaries who are currently renting certain DME competitively bid item(s) and who reside in a CBA. These notifications must meet all of the requirements listed in § 414.408(j)(5)(i) and (ii) for the 30-day, 10-day and 2-day notices that must be sent by suppliers who decide to be grandfathered suppliers. However, there are exceptions regarding the 30-day notice for noncontract suppliers electing not to become grandfathered suppliers. The exceptions are listed in § 414.408(j)(6)(iii)(A) through (C). In addition, suppliers must also comply with the criteria listed in § 414.408(j)(6)(iv).

The burden associated with the information collection requirements in § 414.408(j)(6) is the time and effort necessary for a supplier to make the required notifications to beneficiaries. We estimate that 145 suppliers will not elect to become grandfathered suppliers. Similarly, we estimate that each nongrandfathered supplier will need to make an average of 156 notifications based on an average of 52 beneficiaries per supplier. We estimate that it will take 2 hours to develop the 30-day notification to the beneficiary and 15 minutes to send out each notification. The 10-day notification will take approximately 15 minutes and the 2-day will take approximately 15 minutes. We estimate to send out all 3 notifications it will take a total of approximately 45 minutes. The total burden associated with the requirements in § 414.408(j)(6) is approximately 5,945 hours.

F. ICRs Regarding Claims for Damages (§ 414.425)

Section 414.425(a) states that any aggrieved supplier, including a member of a network that was awarded a contract for the Round 1 Durable Medical Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP), may file a claim under this section for certain alleged damages arising out of MIPPA's termination of the Round 1 DMEPOS CBP contracts. Section 414.425(b) states that a completed claim, including all documentation, must be filed within 90 days of the effective date of the final rule on damages, unless that day is a holiday or Sunday in which case it will revert to the next business day. Section 414.425(c) lists the required documentation for submitting a claim.

The burden associated with this requirement is the time and effort necessary to gather required documentation as specified in § 414.425(c) and submit a claim for damages. This requirement is for a one-time process that will only impact those suppliers who were awarded a contract and were potentially damaged by the termination of their contracts by MIPPA. We awarded contracts to 329 suppliers. We expect that it will take approximately 3 hours for a supplier to gather the necessary documents and to file a claim. We anticipate that anywhere between 5 and 250 suppliers may submit a claim for damages.

While this requirement is subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.4. The information in question is being collected as a result of an administrative action; suppliers are submitting claims for damages caused by the termination of contracts awarded in 2008 under the DMEPOS CBP that were terminated as a result of section 154(a)(1)(A)(iv) of the MIPPA.

G. ICRs Dispute Resolution and Process for Suspension or Termination of Approved CAP Contract and Termination of Physician Participation Under Exigent Circumstances (§ 414.917)

As stated in § 414.97, an approved CAP vendor may appeal that termination by requesting a reconsideration. A determination must be made as to whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. The approved CAP vendor's contract will remain suspended during the reconsideration process.

The burden associated with this requirement is the time and effort necessary for a CAP vendor to request a reconsideration of the termination. While this requirement is subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.4. The burden associated with collecting information subsequent to an administrative action is not subject to the PRA.

H. ICRs Regarding Compendia for Determination of Medically-accepted Indications for Off-label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen (§ 414.930)

As stated in the definition for a publicly transparent process for evaluating therapies in § 414.930(a), a compendium must make the following materials available to the public on its Web site, coincident with the compendium's publication of the related recommendation:

(i) The internal or external request for listing of a therapy recommendation including criteria used to evaluate the request.

(ii) A listing of all the evidentiary materials reviewed or considered by the compendium pursuant to the request.

(iii) A listing of all individuals who have substantively participated in the review or disposition of the request.

(iv) Minutes and voting records of meetings for the review and disposition of the request.

The definition for a publicly transparent process for identifying conflicts of interests in § 414.930(a), states that a compendium must make the following materials available to the public, coincident with the compendium's publication of the related recommendation:

(i) Direct or indirect financial relationships that exist between individuals or the spouse or minor child of individuals who have substantively participated in the development or disposition of compendia recommendations and the manufacturer or seller of the drug or biological being reviewed by the compendium. This may include, for example, compensation arrangements such as salary, grant, contract, or collaboration agreements between individuals or the spouse or minor child of individuals who have substantively participated in the review and disposition of the request and the manufacturer or seller of the drug or biological being reviewed by the compendium.

(ii) Ownership or investment interests between individuals or the spouse or minor child of individuals who have substantively participated in the development or disposition of compendia recommendations and the manufacturer or seller of the drug or biological being reviewed by the compendium.

Based on our estimate, the burden we derived for all our conflict of interest and transparency provisions above, the total burden would range from 1950 hours per compendium with 75 responses to 2600 hours per compendium with 100 responses. The variation in responses is due to the varying size of compendia publications and different processes used by compendia publishers to generate a recommendation. In our estimate we also found that the total burden from respondents would range from 30 hours per compendium with 10 respondents to 2535 hours per compendium with 845 respondents. The variation in respondents depends on a compendium's use of internal or external staff to generate compendia recommendations. Therefore, based on these burden totals, the total burden hours per compendium to comply with our conflict of interest and transparency

provisions ranges from 1980 hours (a compendium with 75 responses and 10 respondents) to 5135 hours (a compendium with 100 responses and 845 respondents). In order to capture the maximum burden for an individual compendium, we are using the highest total hour estimate, 5135 hours, per compendium to comply with our conflict of interest and transparency provisions. In addition, all these provisions could be managed by a qualified administrative assistant at an hourly rate of $33.51 per hour based on the average salary of $69,500 obtained from the Department of Labor.

We are soliciting public comments on the aforementioned requirements and the associated burden estimates in an emergency PRA notice published elsewhere in this **Federal Register.**

TABLE 47—ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN

Regulation section(s)	OMB Control No.	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)
§ 414.408(j)(5)	0938–New	1305	69,165	17.25	22,511
§ 414.408(j)(6)	0938–New	145	22,620	41	5,945
§ 414.930	0938–New	845	900	* 1.83	5,135
Total					33,591

* The average burden for the six tasks associated with the requirements in § 414.930.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this final rule with comment period; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, *Attention:* CMS Desk Officer, [CMS–1413–P]. *Fax:* (202) 395–6974; or *E-mail: OIRA_submission@omb.eop.gov.*

Additional Information Collection Requirements

This final rule with comment period imposes collection of information requirements as outlined in the regulation text and specified above. However, this final rule with comment period also makes reference to several associated information collections that are not discussed in the regulation text contained in this document. The following is a discussion of these information collections, some of which have already received OMB approval.

Part B Drug Payment

The discussion of average sales price (ASP) issues in section II.H.1 of this final rule with comment period does not contain any new information collection requirements with respect to payment for Medicare Part B drugs and biologicals under the ASP methodology. Drug manufacturers are required to submit ASP data to us on a quarterly basis. The ASP reporting requirements are set forth in section 1927(b) of the Act. The burden associated with this requirement is the time and effort required by manufacturers of Medicare Part B drugs and biologicals to calculate, record, and submit the required data to CMS. While the burden associated with this requirement is subject to the PRA, it is currently approved under OMB control number 0938–0921.

Competitive Acquisition Program (CAP)

Section II.H.2. of this final rule with comment period discusses issues related to the competitive acquisition program for Part B drug payment. There are no new information collection requirements associated with the CAP; however, there are several previously approved information collection requests (ICR) associated with the CAP.

TABLE 48—OMB CONTROL NUMBERS

Program component	OMB Control No.	Expiration date
Medicare Part B Drug and Biological CAP	0938–0954	06/30/2011
Medicare Part B Drug and Biological Competitive Acquisition Program Applications [1]	0938–0955	08/31/2012
Competitive Acquisition Program (CAP) for Medicare Part B Drugs: CAP Physician Election Agreement	0938–0987	12/31/2011

[1] An extension of the currently approved ICR is currently in the middle of the mandatory 60-day **Federal Register** notice and comment period. The ICR will be submitted to OMB for review and approval prior to the expiration date.

Physician Quality Reporting Initiative (PQRI)

Section II.G.2. of this final rule with comment period discusses the background of the PQRI, provides information about the measures to be available to eligible professionals who choose to participate in the 2010 PQRI, and the criteria for satisfactory reporting in 2010. Beginning on January 1, 2010, the Secretary is also required by section 1848(m)(3)(C) of the Act, to establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under the PQRI.

With respect to satisfactory submission of data on quality measures by eligible professionals, eligible professionals include physicians, other practitioners as described in section 1842(b)(18)(c) of the Act, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists. Eligible professionals may choose whether to participate and, to the extent they satisfactorily submit data on quality measures for covered professional services, they can qualify to receive an incentive payment. To qualify to receive an incentive payment for 2010, the eligible professional must meet one of the criteria for satisfactory reporting described in sections II.G.2.e. and II.G.2.f. of this final rule with comment period.

For individual eligible professionals, the burden associated with the requirements of this voluntary reporting

initiative is the time and effort associated with eligible professionals identifying applicable PQRI quality measures for which they can report the necessary information and the time and effort associated with eligible professionals selecting a reporting option. We believe it is difficult to accurately quantify the burden because it would vary with each eligible professional by the number of measures applicable to the eligible professional, the eligible professional's familiarity and understanding of the PQRI, and experience with participating in the PQRI. In addition, eligible professionals may employ different methods for incorporating quality measures reporting into the office work flows and are given flexibility for determining which reporting option best fits their needs.

We believe the burden associated with participating in PQRI has declined for those familiar with the program and who have satisfactorily participated in the 2007 PQRI and/or the 2008 PQRI. However, because we anticipate even greater participation in the 2010 PQRI, including participation by eligible professionals who are participating in PQRI for the first time in 2010, we will assign 5 hours as the amount of time needed for eligible professionals to review the list of PQRI quality measures, identify the applicable measures for which they can report the necessary information, review the measure specifications for those measures applicable to the eligible professional, incorporate reporting of the measures selected by the eligible professional into the office work flows, and select a 2010 PQRI reporting option. Information from the Physician Voluntary Reporting Program (PVRP), which was a predecessor to the PQRI, indicated an average labor cost of $50 per hour per practice. To account for salary increases over time, we will use an average practice labor cost of $55 per hour in our estimates based on an assumption of an average annual increase of approximately 3 percent. Thus, we estimate the cost for an eligible professional to review the list of PQRI quality measures, identify the applicable measures for which they can report the necessary information, review the measure specifications for those measures applicable to the eligible professional, incorporate reporting of the selected measures into the office work flows, and select a 2010 PQRI reporting option to be approximately $275 per eligible professional ($55 per hour × 5 hours).

We continue to expect the ongoing costs associated with PQRI participation to decline based on an eligible professional's familiarity with and understanding of the PQRI, experience with participating in the PQRI, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices.

In addition, for claims-based reporting, eligible professionals must gather the required information, select the appropriate quality data codes, and include the appropriate quality data codes on the claims they submit for payment. The PQRI will collect quality data codes as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500. We do not anticipate any new forms or modifications to the existing transaction or form. We also do not anticipate changes to the 837–P or CMS Form 1500 for CY 2010.

Because this is a voluntary program, it is difficult to accurately estimate how many eligible professionals will opt to participate in the PQRI in CY 2010. Information from the ''PQRI 2007 Reporting Experience Report,'' which is available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*, indicates that nearly 110,000 unique TIN/NPI combinations attempted to submit PQRI quality measures data via claims for the 2007 PQRI. Therefore, for purposes of conducting a burden analysis for the 2010 PQRI, we will assume that all eligible professionals who attempted to participate in the 2007 PQRI will also attempt to participate in the 2010 PQRI.

Moreover, the time needed for an eligible professional to review the quality measures and other information, select measures applicable to his or her patients and the services he or she furnishes to them, incorporate reporting of the selected measures into the office work flows, and select a 2010 PQRI reporting option is expected to vary along with the number of measures that are potentially applicable to a given professional's practice. Since eligible professionals are generally required to report on at least 3 measures to earn a PQRI incentive, we will assume that each eligible professional who attempts to submit PQRI quality measures data is attempting to earn a PQRI incentive payment and that each eligible professional reports on an average of 3 measures for this burden analysis.

Based on our experience with the PVRP, we continue to estimate that the time needed to perform all the steps necessary to report each measure (that is, reporting the relevant quality data code(s) for a measure) on claims ranges from 15 seconds (0.25 minutes) to over 12 minutes for complicated cases and/or measures, with the median time being 1.75 minutes. With an average practice labor cost of $55 per hour, the cost associated with this burden ranges from $0.23 in labor time to about $11.00 in labor time for more complicated cases and/or measures, with the cost for the median practice being $1.44.

The total estimated annual burden for this requirement will also vary along with the volume of claims on which quality data is reported. Results from the 2007 PQRI indicate that eligible professionals reported on 1 to 3,331 eligible instances per measure. For all 2007 PQRI measures, the median number of eligible instances reported on per measure was less than 60. On average the median number of eligible instances reported on per measure was about 9. Therefore, for this burden analysis we estimate that for each measure, an eligible professional reports the quality data on 9 cases. The actual number of cases on which an eligible professional will be required to report quality measures data will vary, however, with the eligible professional's patient population and the types of measures on which the eligible professional chooses to report (each measure's specifications includes a required reporting frequency).

Based on the assumptions discussed above, we estimate the total annual burden per eligible professional associated with claims-based reporting to range from 306.75 minutes, or 5.1125 hours [(0.25 minutes per measure × 3 measures × 9 cases per measure) + 5 hours] to 624 minutes, or 10.4 hours [(12 minutes per measure × 3 measures × 9 cases per measure) + 5 hours]. We estimate the total annual cost per eligible professional associated with claims-based reporting to range from $281.21 [($0.23 per measure × 3 measures × 9 cases per measure) + $275] to $572 [($11.00 per measure × 3 measures × 9 cases per measure) + $275].

For registry-based reporting, we are estimating that it would cost an eligible professional approximately $1,000 to participate in a registry based on input we received from commenters (these comments are addressed in the section II.G.2.a. of the preamble). This takes into account the participation fee charged by registries and the fact that this fee often includes services above and beyond what is required for PQRI. However, registries vary in their participation fees as some registries do not charge a participation fee at all or charge only nominal fees. Eligible professionals also need to authorize or instruct the registry to submit quality measures results and

numerator and denominator data on quality measures to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each eligible professional that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf.

Registries interested in submitting quality measure results and numerator and denominator data on quality measures to CMS on their participants' behalf in 2010 will need to complete a self-nomination process in order to be considered ''qualified'' to submit on behalf of eligible professionals unless the registry was qualified to submit on behalf of eligible professionals for the 2009 PQRI and does so successfully. We estimate that the self-nomination process for qualifying additional registries to submit on behalf of eligible professionals for the 2010 PQRI involves approximately 1 hour per registry to draft the letter of intent for self-nomination. It is estimated that each self-nominated entity will also spend 2 hours for the interview with CMS officials and 2 hours for the development of a measure flow. However, the time it takes to complete the measure flow could vary depending on the registry's experience. Additionally, part of the self-nomination process involves the completion of an XML submission by the registry, which is estimated to take approximately 5 hours, but may vary depending on the registry's experience. We estimate that the registry staff involved in the registry self-nomination process have an average labor cost of $50 per hour. Therefore, assuming the total burden hours per registry associated with the registry self-nomination process is 10 hours, we estimate the total cost to a registry associated with the registry self-nomination process to be approximately $500 ($50 per hour × 10 hours per registry).

The burden associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating quality measure results from the data submitted to the registry by its participants and submitting the quality measure results and numerator and denominator data on quality measures to CMS on behalf of their participants. The time needed for a registry to review the quality measures and other information, calculate the measure results, and submit the measure results and numerator and denominator data on the quality measures on their participants' behalf is expected to vary along with the number of eligible professionals reporting data to the registry and the number of applicable measures. However, since it is customary for most registries to provide their participants with information that can be used for the participants' internal quality improvement efforts, we believe that registries already perform many of these activities for their participants. The number of measures that the registry intends to report to CMS and how similar the registry's measures are to CMS' PQRI measures will determine the time burden to the registry.

For EHR-based reporting, the eligible professional must review the quality measures on which we will be accepting PQRI data extracted from EHRs, select the appropriate quality measures, extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS will be new to PQRI for 2010 and participation in this reporting initiative is voluntary, we believe it is difficult to estimate with any degree of accuracy how many eligible professionals will opt to participate in the PQRI through the EHR mechanism in CY 2010. The time needed for an eligible professional to review the quality measures and other information, select measures applicable to his or her patients and the services he or she furnishes to them is expected to be similar for EHR-based reporting and claims-based reporting. Once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the eligible professional associated with submission of data on PQRI quality measures should be minimal.

An EHR vendor interested in having their product(s) be used by eligible professionals to submit PQRI quality measures data to CMS were required to complete a self-nomination process in order for the vendor's product(s) to be considered ''qualified'' for 2010. It is difficult for us to accurately quantify the burden associated with the EHR self-nomination process as there is variation regarding the technical capabilities and experience among vendors. For purposes of this burden analysis, however, we estimate that the time required for an EHR vendor to complete the self-nomination process will be similar to the time required for registries to self-nominate, that is, approximately 10 hours at $50 per hour for a total of $500 per EHR vendor ($50 per hour × 10 hours per EHR vendor).

The burden associated with the EHR-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting 2010 PQRI quality measures. The time needed for an EHR vendor to review the quality measures and other information and program each qualified EHR product to enable eligible professionals to submit PQRI quality measures data to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with PQRI, the vendor's system capabilities, as well as the vendor's programming capabilities. Some vendors already have these necessary capabilities and for such vendors, we estimate the total burden hours to be 40 hours at a rate of $50 per hour for a total burden estimate of $2,000 ($50 per hour × 40 hours per vendor). However, given the variability in the capabilities of the vendors, we believe a more conservative estimate for those vendors with minimal experience would be approximately 200 hours at $50 per hour, for a total estimate of $10,000 per vendor ($50 per hour × 200 hours per EHR vendor).

With respect to the process for group practices to be treated as satisfactorily submitting quality measures data under the 2010 PQRI discussed in section II.G.2. of this final rule with comment period, group practices interested in participating in the 2010 PQRI through the group practice reporting option must complete a self-nomination process similar to the self-nomination process required of registries and EHR vendors. Therefore, we estimate that the self-nomination process for the group practices for the 2010 PQRI involves approximately 2 hours per group practice to review the 2010 PQRI reporting option and make the decision to participate as a group rather than individually and an additional 2 hours per group practice to draft the letter of intent for self-nomination, gather the requested TIN and NPI information, and provide this requested information. It is estimated that each self-nominated entity will also spend 2 hours undergoing the vetting process with CMS officials. We assume that the group practice staff involved in the group practice self-nomination process have an average practice labor cost of $55 per hour. Therefore, assuming the total burden hours per group practice associated with the group practice self-nomination process is 6 hours, we estimate the total cost to a group

practice associated with the group practice self-nomination process to be approximately $330 ($55 per hour × 6 hours per group practice).

The burden associated with the group practice reporting requirements of this voluntary reporting initiative is the time and effort associated with the group practice submitting the quality measures data. For group practices, this would be the time associated with the group practice completing the data collection tool. The information collection components of this data collection tool have been reviewed by OMB and are currently approved under OMB control number 0938–0941, with an expiration date of December 31, 2011, for use in the Physician Group Practice, Medicare Care Management Performance (MCMP), and EHR demonstrations. Based on burden estimates for the PGP demonstration, which uses the same data submission methods as what we will be using for PQRI, we estimate the burden associated with a group practice completing the data collection tool will be approximately 79 hours per physician group. Therefore, we estimate the total annual burden hours per physician group would be approximately 85 hours (2 hours for decision-making + 4 hours for self-nomination + 79 hours for data submission). Based on an average labor cost of $55 per physician group, we estimate the cost per physician group associated with participating in the PQRI group practice reporting option would be $4,675 ($55 per hour × 85 hours per group practice).

The Electronic Prescribing (E-Prescribing) Incentive Program

We believe it is difficult to accurately estimate how many eligible professionals will opt to participate in the E-Prescribing Incentive Program in CY 2010. Information from the ''PQRI 2007 Reporting Experience Report,'' which is available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*, indicates that nearly 110,000 unique TIN/NPI combinations attempted to submit PQRI quality measures data via claims for the 2007 PQRI. Therefore, for purposes of conducting a burden analysis for the 2010 E-Prescribing Incentive Program, we will assume that as many eligible professionals who attempted to participate in the 2007 PQRI will attempt to participate in the 2010 E-Prescribing Incentive Program. As such, we can estimate that nearly 110,000 unique TIN/NPI combinations will participate in the 2010 E-Prescribing Incentive Program.

Section II.G.5. of the preamble discusses the background of the E-Prescribing Incentive Program. Section II.G.5.c. of the preamble provides information on how eligible professionals can qualify to be considered a successful electronic prescriber in 2010 in order to earn an incentive payment. Similar to the PQRI, the E-Prescribing Incentive Program is a voluntary initiative. Eligible professionals may choose whether to participate and, to the extent they meet (1) certain thresholds with respect to the volume of covered professional services furnished and (2) the criteria to be considered a successful electronic prescriber described in section II.G.5.c. of this final rule with comment period, they can qualify to receive an incentive payment for 2010.

For the 2010 E-Prescribing Incentive Program, as discussed in section II.G.5. of the preamble, each eligible professional will need to report the 2010 electronic prescribing measure, which indicates that at least 1 prescription created during an eligible encounter was generated and transmitted electronically using a qualified electronic prescribing system. Similar to PQRI, this measure will be reportable through claims, a qualified registry, or a qualified EHR.

Similar to claims-based reporting for the PQRI, we estimate that the burden associated with the requirements of this incentive program is the time and effort associated with eligible professionals determining whether the electronic prescribing quality measure applies to them, gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims they submit for payment. We expect the ongoing costs associated with participation in the E-Prescribing Incentive Program to decline based on an eligible professional's familiarity with and understanding of the E-Prescribing Incentive Program, experience with participating in the E-Prescribing Incentive Program, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices. Since the E-Prescribing Incentive Program consists of only 1 quality measure, we will assign 1 hour as the amount of time needed for eligible professionals to review the electronic prescribing measure and incorporate reporting of the measure into their office work flows and an additional hour as the amount of time needed for eligible professionals to select an appropriate reporting mechanism for them. At an average cost of approximately $55 per hour (see section XIII.E.2. above for a discussion of how we arrived at this figure), we estimate the total cost to eligible professionals for reviewing the e-prescribing measure, incorporating the reporting of the measure into the office work flows, and selecting an appropriate reporting mechanism to be approximately $110 ($55 per hour × 2 hours).

For claims-based reporting, the quality data codes will be collected as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500. We do not anticipate any new forms or modifications to the existing transaction or form. We also do not anticipate changes to the 837–P or CMS Form 1500 for CY 2010.

Based on our experience with the PVRP described in section II.G.5., we estimate that the time needed to perform all the steps necessary to report the electronic prescribing measure via claims to be 1.75 minutes. We also estimate the cost to perform all the steps necessary to report the electronic prescribing measure to be $1.44 based on the experience with the PVRP described above.

Based on the 2010 criteria for determination of whether an eligible professional is a successful electronic prescriber, we estimate that each eligible professional will report the electronic prescribing measure in 25 instances during the reporting period.

Therefore, we estimate the total annual burden per eligible professional who chooses to participate in the 2010 E-Prescribing Incentive Program through claims-based reporting of the electronic prescribing measure to be 163.75 minutes, or 2.73 hours [(1.75 minutes per measure × 1 measure × 25 cases per measure) + 2 hours]. The total estimated cost per eligible professional to report the electronic prescribing measure is estimated to be $146 [($1.44 per measure × 1 measure × 25 cases per measure) + $110].

Because registry-based reporting of the electronic prescribing measure to CMS will be new for 2010 and participation in this reporting initiative is voluntary, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the registry-based reporting mechanism in CY 2010. We do not anticipate, however, any additional burden for eligible professionals to report data to a registry as eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry for other purposes

(particularly eligible professionals who are already participating in PQRI via the registry-based reporting mechanism). Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program. However, in addition to the 2 hours estimated for the time needed by eligible professionals to review the applicability of the electronic prescribing measure, incorporate reporting of the measure in their practice work flows, and review the available reporting mechanisms to select the registry reporting mechanism, eligible professionals will need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each eligible professional that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

Based on our policy to consider only registries qualified to submit quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf for the 2010 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program, there will be no need for a registry to undergo a separate self-nomination process for the E-Prescribing Incentive Program other than to indicate to us its desire to become a qualified registry for the E-Prescribing Incentive Program at the time that it does so for PQRI. Therefore, we estimate that any additional associated with the registry self-nomination process would be minimal.

The burden associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating results for the electronic prescribing measure from the data submitted to the registry by its participants and submitting the quality measure results and numerator and denominator data on the electronic prescribing quality measure to CMS on behalf of their participants. The time needed for a registry to review the electronic prescribing measure and other information, calculate the measure's results, and submit the measure's results and numerator and denominator data on the measure on their participants' behalf is expected to vary along with the number of eligible professionals reporting data to the registry. However, we believe that registries already perform many of these activities for their participants. Since the E-Prescribing Incentive Program consists of only one measure, we believe that the burden associated with the registry reporting the measure's results and numerator and denominator to CMS on behalf of their participants would be minimal.

For EHR-based reporting, the eligible professional must review the electronic prescribing measure, extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS will be new for 2010 and participation in this reporting initiative is voluntary, it is difficult to accurately estimate how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the EHR-based reporting mechanism in CY 2010. The time needed for an eligible professional to review the electronic prescribing measure and other information to determine whether the measure is applicable to his or her patients and the services he or she furnishes to them and to review the available reporting mechanisms to select the EHR reporting mechanism is expected to be similar for EHR-based reporting and claims-based reporting. Once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the eligible professional associated with submission of data on the electronic prescribing measure should be minimal.

Based on our policy to consider only EHR products qualified for the 2010 PQRI to be qualified for the 2010 E-Prescribing Incentive Program, there will be no need for EHR vendors to undergo a separate self-nomination process for the E-Prescribing Incentive Program and therefore, no additional burden associated with the self-nomination process.

The burden associated with the EHR-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting the 2010 electronic prescribing measure. The time needed for an EHR vendor to review the measure and other information and program each qualified EHR product to enable eligible professionals to submit data on the measure to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with the electronic prescribing measure, the vendor's system capabilities, as well as the vendor's programming capabilities. Since only EHR products qualified for the 2010 PQRI will be qualified for the 2010 E-Prescribing Incentive Program and the E-Prescribing Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable eligible professionals to submit data on the electronic prescribing measure to the CMS-designated clinical data warehouse would be minimal.

Finally, with respect to the process for group practices to be treated as successful electronic prescribers under the 2010 E-Prescribing Incentive Program discussed in section II.G.5., a group practice will be required to report the electronic prescribing measure in at least 2,500 instances. Group practices have the same options as individual eligible professionals in terms of the form and manner for reporting the electronic prescribing measure (that is, group practices have the option of reporting the measure through claims, a qualified registry, or a qualified EHR product). The only difference between an individual eligible professional and group practice reporting of the electronic prescribing measure is the number of times that a group practice is required to report the electronic prescribing measure. Reporting of the electronic prescribing measure can continue to occur at the individual eligible professional level under the electronic prescribing group practice reporting option. In our analysis of the information, however, we will aggregate all of the information reported by the eligible professionals within the group practice to determine whether the group practice reported the measure a sufficient number of times. For group practices that are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through claims-based reporting of the electronic prescribing measure, we estimate the total annual burden to be 74.92 hours [(1.75 minutes per measure × 1 measure × 2,500 cases per measure) + 2 hours]. The total estimated cost per group practice to report the electronic prescribing measure through claims-based reporting is estimated to be $3,710 [($1.44 per measure × 1 measure × 2,500 cases per measure) + $110].

For group practices that are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through registry-based reporting of the

electronic prescribing measure, we do not anticipate any additional burden to report data to a registry as group practices opting for registry-based reporting would more than likely already be reporting data to the registry for other purposes, such as for the PQRI. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program. However, in addition to the 2 hours estimated for the time needed by group practices to review the electronic prescribing measure to determine its applicability to the practice, incorporate reporting of the electronic prescribing measure into the practice's work flows, and review available reporting mechanisms to select group practice reporting of the measure through a qualified registry, the group practices will need to authorize or instruct the registry to submit the measure results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each group practice that wishes to authorize or instruct the registry to submit quality measure results and numerator and denominator data on the electronic prescribing measure to CMS on its behalf.

For group practices that are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through EHR-based reporting of the electronic prescribing measure, once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the group practice associated with submission of data on the electronic prescribing measure should be minimal.

In addition to the burden associated with group practices reporting the electronic prescribing measure, group practices will also be required to self-nominate in order to participate in the 2010 E-Prescribing Incentive Program under the group practice reporting option. Since we are limiting participation in the electronic prescribing group practice reporting option to those group practices selected to participate in the PQRI group practice reporting option, there will not be a separate group practice self-nomination process for the E-Prescribing Incentive Program and, thus, no additional burden.

We invite comments on this burden analysis, including the underlying assumptions used in developing our burden estimates.

XII. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

XIII. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimate, as discussed below in this section, that the PFS provisions included in this final rule with comment period will redistribute more than $100 million in 1 year. Therefore, we estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that most hospitals and most other providers are small entities as that term is used in the RFA (including small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (having revenues of less than $7.0 million to $34.5 million in any 1 year) (for details see the SBA's Web site at *http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf* (refer to the 620000 series). Individuals and States are not included in the definition of a small entity.

The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

For purposes of the RFA, physicians, NPPs, and suppliers including IDTFs are considered small businesses if they generate revenues of $7 million or less based on SBA size standards. Approximately 95 percent of physicians are considered to be small entities. There are over 1 million physicians, other practitioners, and medical suppliers that receive Medicare payment under the PFS.

For purposes of the RFA, approximately 85 percent of suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are considered small businesses according to the SBA size standards. We estimate that approximately 105,000 DMEPOS suppliers are enrolled in Medicare currently and bill Medicare for DMEPOS each year. Total annual estimated Medicare revenues for DMEPOS suppliers are approximately $11.7 billion in 2008 for which $8.7 billion was for fee-for-service (FFS) and $3.0 billion was for managed care.

For purposes of the RFA, approximately 80 percent of clinical diagnostic laboratories are considered small businesses according to the SBA size standards.

Ambulance providers and suppliers for purposes of the RFA are also considered to be small entities.

In addition, most ESRD facilities are considered small entities for purposes of the RFA, either based on nonprofit status or by having revenues of $7 million to $34.5 million or less in any year. We note that a considerable number of ESRD facilities are owned and operated by large dialysis organizations (LDOs) or regional chains,

which would have total revenues more than $34.5 million in any year if revenues from all locations are combined. However, the claims data we use to estimate payments for this RFA and RIA does not identify which dialysis facilities are parts of an LDO, regional chain, or other type of ownership. Each individual dialysis facility has its own provider number and bills Medicare using this number. Therefore, we consider each ESRD to be a small entity for purposes of the RFA. We consider a substantial number of entities to be significantly affected if the final rule with comment period has an annual average impact on small entities of 3 to 5 percent or more. The majority of ESRD facilities will experience impacts of less than 2 percent of total revenues. There are 946 nonprofit ESRD facilities with a combined increase of 0.9 percent in overall payments relative to current overall payments. We note that although the overall effect of the wage index changes is budget neutral, there are increases and decreases based on the location of individual facilities. The analysis and discussion provided in this section and elsewhere in this final rule with comment period complies with the RFA requirements.

Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this final rule with comment period constitutes our regulatory flexibility analysis for the remaining provisions and addresses comments received on these issues.

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. Any such regulatory impact analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. We do not believe this final rule with comment period has impact on significant operations of a substantial number of small rural hospitals because most dialysis facilities are freestanding. While there are 176 rural hospital-based dialysis facilities, we do not know how many of them are based at hospitals with fewer than 100 beds. However, overall, the 176 rural hospital-based dialysis facilities will experience an estimated 1.1 percent increase in payments. As a result, this rule will not have a significant impact on small rural hospitals. Therefore, the Secretary has determined that this final rule with comment period will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2009, that threshold is approximately $133 million. This final rule with comment period will not mandate any requirements for State, local, or tribal governments. Medicare beneficiaries are considered to be part of the private sector and as a result a more detailed discussion is presented on the Impact of Beneficiaries in section V. of this regulatory impact analysis. Rather, it focuses on certain categories of cost, mainly those ''Federal mandate'' costs resulting from (A) imposing enforceable duties on State, local, or tribal governments, or on the private sector, or (B) increasing the stringency of conditions in, or decreasing the funding of, State, local, or tribal governments under entitlement programs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement 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 and have determined that this regulation would not have any substantial direct effect on State or local governments, would not preempt States, or otherwise have a Federalism implication.

We have prepared the following analysis, which together with the information provided in the rest of this preamble, meets all assessment requirements. The analysis explains the rationale for and purposes of this final rule with comment period; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we will use to minimize the burden on small entities. As indicated elsewhere in this rule, we are implementing a variety of changes to our regulations, payments, or payment policies to ensure that our payment systems reflect changes in medical practice and the relative value of services. We provide information for each of the policy changes in the relevant sections of this final rule with comment period. We are unaware of any relevant Federal rules that duplicate, overlap, or conflict with this final rule with comment period. The relevant sections of this rule contain a description of significant alternatives if applicable.

Comment: We received comments on the CY 2010 PFS proposed rule stating that we failed to address the impact of the changes on small businesses and did not propose any measures for mitigating the negative impact the proposals might have on such businesses. One commenter stated that most portable x-ray suppliers are small businesses and that the policy changes will adversely affect them. Another commenter, representing providers of integrated cancer care, also expressed concern about the negative impact the proposed changes would have on small businesses that furnish radiation therapy services. The commenters outlined specific concerns with respect to the proposals concerning practice expense, including the change with respect to assumption for equipment utilization, the changes to malpractice RVUs, as well as application of the projected −21.5 update adjustment under the SGR.

Response: In Addendum B of the CY 2010 PFS proposed rule, we provided the proposed payment rates for the HCPCS codes paid under the PFS. Any physician or supplier of PFS services can determine the impact of the proposed Medicare payment rates using their own mix of services. In addition, we publish average impacts by Medicare specialty to assist the public in commenting on the proposed rule. The methodology that we use to develop the RVUs is publicly available as are the data files that we use in the calculations and impact analyses.

We did review the potential impact of our revised policies in the regulatory impact analysis. In light of the comments received on the proposed rule, we have revised many of the proposals made in the proposed rule such that we estimate that the impact on portable x-ray suppliers and providers of radiation therapy services in this final rule with comment period will be significantly different than in the proposed rule, as shown in Table 49. However, the PFS update, which is based in part on the SGR, is required by law, affects all PFS services, and we have no discretion to waive this provision for small businesses.

B. RVU Impacts

1. Resource-Based Work, PE, and MP RVUs

Section 1848(c)(2)(B)(ii) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by

more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make adjustments to preserve BN.

Our estimates of changes in Medicare revenues for PFS services compare payment rates for CY 2009 with payment rates for CY 2010 using CY 2008 Medicare utilization for all years. To the extent that there are year-to-year changes in the volume and mix of services provided by physicians, the actual impact on total Medicare revenues will be different than those shown in Table 49. The payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician provides. The average change in total revenues would be less than the impact displayed here because physicians furnish services to both Medicare and non-Medicare patients and specialties may receive substantial Medicare revenues for services that are not paid under the PFS. For instance, independent laboratories receive approximately 80 percent of their Medicare revenues from clinical laboratory services that are not paid under the PFS.

Table 49 shows only the payment impact on PFS services. The following is an explanation of the information represented in Table 49:

- Specialty: The physician specialty or type of practitioner/supplier.
- Allowed charges: Allowed charges are the PFS amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all services furnished by physicians, practitioners, or suppliers within a specialty to arrive at the total allowed charges for the specialty.
- Impact of Work RVU changes for the CY 2010 PFS.
- Impact of PE RVU changes (Full) if these changes were fully implemented in CY 2010 PFS. These are not the estimated CY 2010 impacts since we have implemented a 4-year transition to the new PE RVUs for existing codes.
- Impact of the CY 2010 PE RVU changes under the 4-year transition (Tran) adopted in this final rule with comment period. These are the estimated CY 2010 impacts. Note that the transition does not apply to new and significantly revised codes.
- Impact of MP RVU changes for the CY 2010 PFS.
- Combined impact of all RVU changes (Full) if these changes were fully implemented in CY 2010 PFS. These are not the estimated CY 2010 impacts since we have implemented a 4-year transition to the new PE RVUs for existing codes. These impacts are prior to the application of the CY 2010 negative PFS CF update under the current statute.
- Combined impact of all of the estimated CY 2010 RVU changes under the 4-year transition (Tran) adopted in this final rule with comment period for the PE changes. These are the estimated CY 2010 impacts, prior to the application of the CY 2010 negative PFS CF update under the current statute.

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TABLE 49: CY 2010 Total Allowed Charge Impact for Work, Practice Expense, and Malpractice Changes*

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
				Impact of PE RVU Changes**			Combined Impact	
	Specialty	Allowed Charges (mil $)	Impact of Work RVU Changes	Full	Tran	Impact of MP RVU Changes	Full	Tran
1	TOTAL	77,796	0%	0%	0%	0%	0%	0%
2	ALLERGY/IMMUNOLOGY	173	0%	-1%	0%	0%	-2%	0%
3	ANESTHESIOLOGY	1,744	0%	4%	1%	0%	3%	0%
4	CARDIAC SURGERY	373	-1%	-1%	0%	2%	1%	1%
5	CARDIOLOGY	7,158	-1%	-10%	-5%	-1%	-13%	-8%
6	COLON AND RECTAL SURGERY	130	-1%	4%	1%	1%	4%	1%
7	CRITICAL CARE	223	-1%	2%	1%	1%	3%	1%
8	DERMATOLOGY	2,520	1%	1%	1%	1%	3%	3%
9	EMERGENCY MEDICINE	2,416	0%	2%	1%	0%	3%	1%
10	ENDOCRINOLOGY	374	-1%	3%	0%	0%	2%	0%
11	FAMILY PRACTICE	5,094	2%	5%	2%	1%	7%	4%
12	GASTROENTEROLOGY	1,792	-2%	0%	0%	1%	0%	-1%
13	GENERAL PRACTICE	727	1%	4%	1%	0%	6%	3%
14	GENERAL SURGERY	2,227	-1%	3%	1%	1%	4%	1%
15	GERIATRICS	170	1%	6%	2%	1%	8%	3%
16	HAND SURGERY	89	-1%	3%	1%	-1%	2%	-1%
17	HEMATOLOGY/ONCOLOGY	1,897	0%	-5%	-1%	0%	-6%	-1%
18	INFECTIOUS DISEASE	554	-1%	3%	0%	1%	3%	0%
19	INTERNAL MEDICINE	10,133	1%	4%	1%	1%	5%	2%
20	INTERVENTIONAL PAIN MANAGE.	356	-2%	3%	-1%	0%	0%	-3%
21	INTERVENTIONAL RADIOLOGY	225	-1%	-9%	-2%	0%	-10%	-3%
22	NEPHROLOGY	1,803	-1%	2%	0%	1%	2%	1%
23	NEUROLOGY	1,414	-3%	4%	1%	0%	1%	-2%
24	NEUROSURGERY	591	-1%	2%	0%	0%	1%	-1%
25	NUCLEAR MEDICINE	74	-5%	-15%	-10%	-2%	-23%	-18%
26	OBSTETRICS/GYNECOLOGY	624	0%	0%	-1%	0%	0%	-1%
27	OPHTHALMOLOGY	4,758	0%	11%	3%	2%	13%	5%
28	ORTHOPEDIC SURGERY	3,261	0%	3%	1%	-1%	2%	0%
29	OTOLARNGOLOGY	933	-1%	1%	-1%	0%	0%	-2%
30	PATHOLOGY	994	0%	-1%	1%	-1%	-3%	-1%
31	PEDIATRICS	65	1%	3%	1%	0%	4%	2%
32	PHYSICAL MEDICINE	824	-1%	6%	2%	0%	5%	1%
33	PLASTIC SURGERY	284	0%	4%	1%	1%	5%	2%
34	PSYCHIATRY	1,095	0%	2%	1%	1%	3%	2%
35	PULMONARY DISEASE	1,765	-1%	2%	0%	1%	2%	0%
36	RADIATION ONCOLOGY	1,809	0%	-3%	0%	-2%	-5%	-1%
37	RADIOLOGY	5,056	0%	-14%	-3%	-2%	-16%	-5%
38	RHEUMATOLOGY	493	0%	-1%	0%	0%	-2%	-1%
39	THORACIC SURGERY	389	-1%	0%	0%	2%	1%	1%
40	UROLOGY	1,993	-1%	-8%	-3%	0%	-10%	-4%
41	VASCULAR SURGERY	656	-1%	-3%	-2%	0%	-3%	-2%
42	AUDIOLOGIST	36	-1%	-16%	-9%	-7%	-23%	-17%
43	CHIROPRACTOR	713	0%	3%	1%	1%	4%	2%
44	CLINICAL PSYCHOLOGIST	544	0%	-8%	-2%	0%	-8%	-2%
45	CLINICAL SOCIAL WORKER	362	0%	-7%	-1%	0%	-7%	-1%
46	NURSE ANESTHETIST	681	0%	4%	1%	0%	4%	1%
47	NURSE PRACTITIONER	1,018	1%	5%	1%	1%	6%	3%
48	OPTOMETRY	848	1%	10%	3%	1%	12%	5%
49	ORAL/MAXILLOFACIAL	36	-1%	4%	1%	0%	3%	0%

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
	Specialty	Allowed Charges (mil $)	Impact of Work RVU Changes	Impact of PE RVU Changes**		Impact of MP RVU Changes	Combined Impact	
				Full	Tran		Full	Tran
	SURGERY							
50	PHYSICAL/OCCUPATIONAL THERAPY	1,883	0%	9%	3%	-1%	8%	2%
51	PHYSICIAN ASSISTANT	757	0%	4%	1%	0%	5%	2%
52	PODIATRY	1,682	1%	6%	2%	-1%	6%	2%
53	DIAGNOSTIC TESTING FACILITY	923	-1%	-29%	-7%	-4%	-34%	-12%
54	INDEPENDENT LABORATORY	970	0%	-5%	0%	-1%	-7%	-1%
55	PORTABLE X-RAY SUPPLIER	87	0%	8%	3%	-1%	7%	2%

* Does not include the impact of the current statute CY 2010 negative update except as applied in the OPPS imaging cap comparison (see next footnote). Rows may not sum to total due to rounding.

** Note: The statute caps the PFS imaging payment amount at the comparable payment amount in the hospital outpatient prospective payment system (OPPS) cap. In the absence of the negative current statute CY 2010 PFS update, the proposed fully implemented PE change to the equipment utilization rate for expensive diagnostic equipment from 50 percent to 90 percent would increase expenditures by less than 1 percent due to a loss of savings from the OPPS cap.

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2. Resource-Based Work, PE, and MP RVUs Impacts

a. Work RVU Impacts

The average work RVU impacts are primarily attributable to the changes for consultation services. As described earlier in this final rule with comment period, we are proposing to no longer recognize the billing codes for consultation services so we are budget neutrally eliminating the use of all consultation codes (except for telehealth) and have allocated the work RVUs that were allotted to these services to the work RVUs for new and established office visit services, initial hospital visits, and initial nursing facility visits to reflect this change.

In addition, the impacts reflect the work done by the AMA RUC related to the Five-Year Review Identification Workgroup's Codes Reported Together screen. Based upon the AMA RUCs review of the myocardial perfusion imaging family of services, it was determined that some of the existing codes for these services are performed together more than 95 percent of the time and were thus referred to CPT for creation of new bundled services. In recognition of the efficiencies associated with the services being performed together, there are less aggregate RVUs under the new bundled 2010 CPT coding structure and pricing than there are under the current 2009 CPT coding structure and pricing. These fewer aggregate RVUs will be offset by an adjustment to the CF in order to maintain overall BN. For further information on the myocardial perfusion imaging family coding changes, see section III.F.4. of this final rule with comment period.

b. PE RVUs Impacts

The PE RVU impacts are primarily attributable to the incorporation of PE data from the Physician Practice Information Survey (PPIS). For a discussion of the use of this updated survey data, see section II.A.2. of this final rule with comment period. The impacts are shown both as if they were fully implemented in CY 2010 and under our 4-year transition policy to the new PE RVUs for existing codes that have not been substantially revised.

For IDTFs, the impact of our change in the utilization rate for expensive diagnostic equipment is also significant. We estimate that for IDTFs, the utilization rate change will result in a fully implemented impact of approximately −2 percent after taking into account the OPPS payment cap. This −2 percent impact is included in the −29 percent fully implemented PE RVU impact shown in Table 49 for IDTFs. The change in the utilization rate for expensive diagnostic imaging equipment does not significantly impact overall payments for other specialties after taking into account the OPPS payment cap.

The impacts also reflect the reduced utilization for the myocardial perfusion imaging family of services stemming from the AMA RUC's review of these services as described above.

The payment impact for an individual physician may be different from the average, based on the mix of services the physician provides. Using the RVU information contained in Appendix B, an impact can be calculated for any particular mix of services either under the fully implemented RVUs or the 4-year transition RVUs.

c. Malpractice RVU Impacts

The average MP RVU impacts are attributable to the changes adopted for the Five-Year Review of MP RVUs described earlier in this final rule with comment period. Of particular note are the impacts on the specialties of Audiology (−7 percent), and IDTFs (−4 percent). These impacts are primarily driven by the expansion of the MP premium data collection and the changes to the methodology for TC services.

d. Combined Impact

Column E of Table 49 displays the combined average impact of all RVU changes by specialty. The impacts are shown both as if the new PE RVUs were fully implemented in CY 2010 and under our 4-year transition policy to the new PE RVUs for existing codes that have not been significantly revised.

The estimated CY 2010 transition impacts range from increases of +5 percent for ophthalmology to decreases of −18 percent for nuclear medicine. The effect of our policies on primary care specialties such as General Practice, Family Practice, Internal Medicine, and Geriatrics are positive with CY 2010 transition increases ranging from +2 percent to +4 percent. Again, these impacts are prior to the application of the negative CY 2010 CF update under the current statute.

Table 49 shows the estimated transition impact on total payments for selected high-volume procedures of all of the changes discussed previously, including the effect of the CY 2010 negative PFS CF update. We selected

these procedures because they are the most commonly furnished by a broad spectrum of physician specialties. There are separate columns that show the change in the facility rates and the non-facility rates. For an explanation of facility and non-facility PE, refer to Addendum A of this final rule with comment period.

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TABLE 50: Impact of the Final Rule with Comment Period and Estimated Physician Update on 2010 Payment for Selected Procedures

CPT[1]/ HCPCS	MOD	Description	Facility			Non-facility		
			2009 ($)	2010 ($)	Percent Change	2009 ($)	2010 ($)	Percent Change
11721		Debride nail, 6 or more	27.77	20.74	-25%	40.39	31.25	-23%
17000		Destruct premalg lesion	48.69	40.90	-16%	69.97	57.95	-17%
27130		Total hip arthroplasty	1359.71	1082.84	-20%	NA	NA	NA
27244		Treat thigh fracture	1144.39	917.52	-20%	NA	NA	NA
27447		Total knee arthroplasty	1456.37	1158.40	-20%	NA	NA	NA
33533		CABG, arterial, single	1892.05	1534.21	-19%	NA	NA	NA
35301		Rechanneling of artery	1067.93	868.66	-19%	NA	NA	NA
43239		Upper GI endoscopy, biopsy	165.55	134.08	-19%	323.16	257.08	-20%
66821		After cataract laser surgery	251.38	216.45	-14%	266.53	228.67	-14%
66984		Cataract surg w/iol, 1 stage	638.74	549.09	-14%	NA	NA	NA
67210		Treatment of retinal lesion	561.56	478.93	-15%	580.67	493.98	-15%
71010		Chest x-ray	NA	NA	NA	24.16	18.18	-25%
71010	26	Chest x-ray	9.02	7.10	-21%	9.02	7.10	-21%
77056		Mammogram, both breasts	NA	NA	NA	107.48	82.95	-23%
77056	26	Mammogram, both breasts	44.36	34.66	-22%	44.36	34.66	-22%
77057		Mammogram, screening	NA	NA	NA	81.15	61.64	-24%
77057	26	Mammogram, screening	35.71	27.84	-22%	35.71	27.84	-22%
77427		Radiation tx management, x5	188.27	153.11	-19%	188.27	153.11	-19%
78465	26	Heart image (3d), multiple	78.99	62.21	-21%	78.99	62.21	-21%
88305	26	Tissue exam by pathologist	37.15	28.97	-22%	37.15	28.97	-22%
90801		Psy dx interview	128.04	100.27	-22%	152.92	121.01	-21%
90862		Medication management	45.08	35.79	-21%	55.18	44.31	-20%
90935		Hemodialysis, one evaluation	66.36	53.12	-20%	NA	NA	NA
92012		Eye exam established pat	45.80	38.35	-16%	70.69	58.80	-17%

CPT[1]/ HCPCS	MOD	Description	Facility			Non-facility		
			2009 ($)	2010 ($)	Percent Change	2009 ($)	2010 ($)	Percent Change
92014		Eye exam & treatment	70.33	58.80	-16%	103.15	85.79	-17%
92980		Insert intracoronary stent	847.93	644.53	-24%	NA	NA	NA
93000		Electrocardiogram, complete	20.92	NA	NA	20.92	15.62	-25%
93010		Electrocardiogram report	9.02	7.10	-21%	9.02	7.10	-21%
93015		Cardiovascular stress test	100.27	73.00	-27%	100.27	73.00	-27%
93307	26	Echo exam of heart	49.77	38.35	-23%	49.77	38.35	-23%
93510	26	Left heart catheterization	248.86	185.21	-26%	248.86	185.21	-26%
98941		Chiropractic manipulation	30.30	24.15	-20%	33.90	27.27	-20%
99203		Office/outpatient visit, new	68.17	57.38	-16%	91.97	76.98	-16%
99213		Office/outpatient visit, est	44.72	38.06	-15%	61.31	51.70	-16%
99214		Office/outpatient visit, est	69.25	58.80	-15%	92.33	77.55	-16%
99222		Initial hospital care	122.63	100.27	-18%	NA	NA	NA
99223		Initial hospital care	180.33	147.14	-18%	NA	NA	NA
99231		Subsequent hospital care	37.15	30.11	-19%	NA	NA	NA
99232		Subsequent hospital care	66.72	54.26	-19%	NA	NA	NA
99233		Subsequent hospital care	95.58	77.83	-19%	NA	NA	NA
99236		Observ/hosp same date	207.38	166.18	-20%	NA	NA	NA
99239		Hospital discharge day	96.30	77.83	-19%	NA	NA	NA
99243		Office consultation	97.38	Discontinued	Discontinued	124.79	Discontinued	Discontinued
99244		Office consultation	154.00	Discontinued	Discontinued	184.30	Discontinued	Discontinued
99253		Inpatient consultation	114.69	Discontinued	Discontinued	NA	NA	NA
99254		Inpatient consultation	165.55	Discontinued	Discontinued	NA	NA	NA
99283		Emergency dept visit	61.31	48.57	-21%	NA	NA	NA
99284		Emergency dept visit	114.33	91.18	-20%	NA	NA	NA
99291		Critical care, first hour	212.07	170.15	-20%	253.91	203.39	-20%
99292		Critical care, addl 30 min	106.04	84.93	-20%	114.69	91.75	-20%
99348		Home visit, est patient	NA	NA	NA	79.35	63.91	-19%
99350		Home visit, est patient	NA	NA	NA	160.86	130.38	-19%
G0008		Admin influenza virus vac	NA	NA	NA	20.92	16.76	-20%

1 CPT codes and descriptions are copyright 2010 American Medical Association. All Rights Reserved. Applicable FARS/DFARS.

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C. Geographic Practice Cost Indices (GPCIs)

As discussed in section II.B. of this final rule with comment period, the application of the 1.000 work GPCI floor, as extended by section 134(a) of the MIPPA, expires effective January 1, 2010. As a result, 54 (out of 89) PFS localities will receive a decrease in their work GPCI. Puerto Rico receives the largest decrease (−9.6 percent), followed by South Dakota (−5.8 percent), North Dakota (−5.3 percent), Rest of Missouri (−5.1 percent), and Montana (−5.0 percent).

D. Medicare Telehealth Services

In section II.D. of this final rule with comment period, we are adding individual health behavior and assessment services (as described by HCPCS codes 96150 through 96152) to the list of telehealth services. We are also revising § 410.78 to specify that the G-codes for follow-up inpatient telehealth consultations (as described by HCPCS codes G0406 through G0408) include follow-up telehealth consultations furnished to beneficiaries in hospitals and skilled nursing facilities.

The total annual Medicare payment amount for telehealth services (including the originating site facility fee) is approximately $2 million. Previous additions to the list of telehealth services have not resulted in a significant increase in Medicare program expenditures. While we believe that these proposals will provide more beneficiaries with access to these services, we do not anticipate that these changes will have a significant budgetary impact on the Medicare program.

E. MIPPA Provisions

1. Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services

This section of the MIPPA will have a positive impact on Medicare patients because coinsurance payment percentages for outpatient mental health services will be gradually reduced from January 1, 2010 through January 1, 2014. At the conclusion of this 5-year period, Medicare patients will pay the same coinsurance payment percentage for outpatient mental health services as they currently pay for most other health services under the Medicare Part B program.

Since the inception of the Medicare Part B program, Medicare patients have been required to pay for a greater percentage of the cost of outpatient mental health treatment services than for other health services because of the Medicare payment limitation (the outpatient mental health treatment limitation). While a dollar cap that previously applied to mental health services was eliminated January 1, 1991, the statute maintained the 62½ percent limitation on the recognition of incurred expenses for these services. This limitation of 62½ percent effectively reduces the program's payment for mental health services to 50 percent, leaving a Medicare patient responsible for paying the other half of these expenses through coinsurance. The 62½ percent limitation will remain in effect until December 31, 2009.

During the transition, the Medicare Part B program will incur increased expenditures as Medicare patients pay less out-of-pocket for outpatient mental health services until, in 2014, patients will pay only the deductible (if applicable) and 20 percent coinsurance. Section 102 of the MIPPA will shift cost-sharing for mental health services from Medicare patients to the program. This provision will result in a cost impact to the Medicare program of approximately $100 million for CY 2010. As section 102 of the MIPPA is implemented, the impact of the changes to the coinsurance payment percentages (that is, recognized incurred expenses) for Medicare patients and the program is as shown in Table 51.

TABLE 51: Impact of the Changes to the Coinsurance Payment Percentages under Section 102 of the MIPPA

CY 2009 and prior calendar years – Medicare limitation, 62.50 percent of recognized incurred expenses
Medicare Patient pays – 50%
Medicare Part B pays – 50%
CY 2010 and CY 2011 – Medicare limitation, 68.75 percent of recognized incurred expenses
Medicare Patient pays – 45%
Medicare Part B pays – 55%
CY 2012 – Medicare limitation, 75 percent of recognized incurred expenses
Medicare Patient pays – 40%
Medicare Part B pays – 60%
CY 2014 – No limitation, 100.00 percent of recognized incurred expenses
Medicare Patient pays – 20%
Medicare Part B pays – 80%

2. Section 131(b): Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting Initiative (PQRI)

As discussed in section II.G.2. of this final rule with comment period, the 2010 PQRI measures satisfy the requirement of section 1848(k)(2)(D) of the Act that the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish. As discussed in section II.G.2.d. of this final rule with comment period, we are also offering options in 2010 for reporting the 2010 PQRI measures via submission of data to a qualified clinical registry, options for reporting some of the 2010 PQRI measures via submission of data extracted from a qualified EHR, options for reporting on measures groups rather than individual measures, and options for group practices to be treated as satisfactorily submitting quality data under the PQRI. We received some comments regarding the cost estimates for PQRI included in the CY 2010 PFS proposed rule (74 FR 33655 through 33657). These comments have been addressed in section II.G.2. of this final rule with comment period or by revisions to our cost estimates below, where appropriate.

Although there may be some cost incurred for maintaining the measures used in the PQRI and their associated code sets, and for expanding an existing clinical data warehouse to accommodate registry-based reporting and EHR-based reporting for the PQRI, we do not anticipate a significant cost impact on the Medicare program.

Participation in the PQRI by eligible professionals is voluntary and eligible professionals and group practices may have different processes for integrating the PQRI into their practices' work flows. Therefore, it is difficult to accurately estimate the impact of the PQRI on providers. We note also that for eligible professionals who satisfactorily submit PQRI quality measures, some (if not all) of the costs incurred by the professional to participate in PQRI may be offset by the PQRI incentive payment amount earned.

With respect to satisfactory submission of data on quality measures by eligible professionals, one factor that influences the cost to eligible professionals is the time and effort associated with eligible professionals identifying applicable PQRI quality measures for which they can report the necessary information. We have no way to accurately quantify the burden because it would vary with each eligible professional by the number of measures applicable to the eligible professional, the eligible professional's familiarity, understanding of the PQRI, and experience with participating in the PQRI, and the reporting option selected by the eligible professional. In addition, eligible professionals may employ different methods for incorporating reporting of their selected measures into the office work flows. Therefore, based on an assumption that eligible professionals will select 3 measures on average and our own estimates that it takes at least 1 hour to read and understand each measure, we will assign 3 hours as the amount of time needed for eligible professionals to review the PQRI quality measures, identify the applicable measures for which they can report the necessary information, and incorporate reporting of the selected measures into the office work flows. After considering the comments received, that indicated that we need to include time for eligible professionals to review all of the reporting options, and our own estimates of the amount of time it takes to read and digest the reporting options, we will also assign an additional 2 hours as the amount of time needed for eligible professionals to review the 2010 PQRI reporting options and select the option most appropriate for their practice. Information from the Physician Voluntary Reporting Program (PVRP), which was a predecessor to the PQRI, indicated an average practice labor cost of approximately $50 per hour. To account for salary increases over time, we will use an average practice labor cost of $55 per hour for our estimates based on an assumption of an average annual increase of approximately 3 percent. Thus, we estimate the cost for an eligible professional to review the PQRI quality measures, identify the applicable measures for which they can report the necessary information, incorporate reporting of the selected measures into the office work flows, review, and select an appropriate reporting option to be approximately $275 per eligible professional ($55 per hour × 5 hours).

For claims-based PQRI reporting, one factor in the cost to eligible professionals is the time and effort associated with gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the Medicare Part B claims an eligible professional submits for payment. Information from the PVRP estimates that the time needed to perform all the steps necessary to report each measure 1 time (that is, reporting the relevant quality data code(s) for a measure on 1 case) on claims ranges from 15 seconds (0.25 minutes) to over 12 minutes for complicated cases and/or measures, with the median time being 1.75 minutes. With an average practice labor cost of $55 per hour, the cost to eligible professionals to perform all the steps necessary to report 1 quality measure 1 time ranges from $0.23 in labor time to about $11.00 in labor time for more complicated cases and/or measures. For the median practice, the cost is about $1.44 in labor time per measure per reporting instance. Eligible professionals generally are required to report at least 3 measures to satisfactorily report PQRI quality measures data. Therefore, for purposes of this impact analysis we will assume that eligible professionals participating in the 2010 PQRI will report an average of 3 measures each.

The cost of implementing claims-based reporting of PQRI quality measures data will vary with the volume of claims on which quality data is reported. Results from the 2007 PQRI indicate that eligible professionals reported on 1 to 3,331 eligible instances per measure. For all 2007 PQRI measures, the median number of eligible instances reported on per measure was less than 60. On average the median number of eligible instances reported on per measure was about 9. Therefore, for this analysis we estimate that for each measure, an eligible professional reports the quality data on 9 cases. The actual number of cases on which an eligible professional will be required to report quality measures data will vary, however, with the eligible professional's patient population and the types of measures on which the eligible professional chooses to report (each measure's specifications include a required reporting frequency).

Based on the assumptions discussed above, we estimate the total annual cost per eligible professional associated with claims-based reporting to range from $281.21 [($0.23 per measure × 3 measures × 9 cases per measure) + $275] to $572.00 [($11.00 per measure × 3 measures × 9 cases per measure) + $275].

For registry-based reporting, eligible professionals must generally incur a cost to submit data to registries. Estimated fees for using a qualified registry range from no charge, or a nominal charge, for an eligible professional to use the registry to costing eligible professionals several thousand dollars, with a majority of registries charging fees ranging from $500–$1,000. Registries also often

provide services above and beyond what is required for PQRI though and our impact analysis is limited to the incremental costs associated with participation in PQRI. Nevertheless, after considering the information above with respect to the qualified registries and the comments received, which offered anecdotal information that the annual cost to one practice of participating in a specific registry is approximately $3,000, we will estimate the cost incurred by an eligible professional to participate in PQRI via registry-based reporting to be approximately $1,000 per eligible professional.

In addition, an eligible professional who chooses to submit PQRI quality measures results and numerator and denominator data on quality measures through a registry more than likely is already reporting data to the registry for other purposes. Little, if any, additional data needs to be reported to the registry for purposes of participation in the 2010 PQRI. Therefore, there should be little additional cost to the eligible professional associated with submitting data to the registry.

Registries interested in submitting quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf must complete a self-nomination process in order to be considered ''qualified'' to submit on behalf of eligible professionals. We estimate the registry self-nomination process to cost approximately $500 per registry ($50 per hour × 10 hours per registry). This cost estimate includes the cost of submitting the self-nomination letter to CMS and completing the CMS vetting process. Our estimate of a $50 per hour average labor cost for registries is based on the assumption that registry staff include IT professionals whose average hourly rates range from $36 to $84 per hour depending on experience, with an average rate of nearly $50 per hour for a mid-level programmer.

The cost to the registry associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating quality measure results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. The time needed for a registry to review the quality measures and other information, calculate the measures results, and submit the measures results and numerator and denominator data on the quality measures on their participants' behalf is expected to vary along with the number of eligible professionals reporting data to the registry and the number of applicable measures. However, since it is customary for most registries to provide their participants with information that can be used for the participants' internal quality improvement efforts, we believe that registries already perform many of these activities for their participants.

For EHR-based reporting, an eligible professional generally would incur a cost associated with purchasing an EHR product. The cost of purchasing an EHR product can range anywhere from as low as $500 to well over $50,000. After considering the information above and the comments received, we estimate that, on average, it costs between $15,000 and $25,000 to purchase an EHR product. An EHR vendor interested in having their product(s) be used by eligible professionals to submit PQRI quality measures data to CMS were required to complete a self-nomination process in order for the vendor's product(s) to be considered ''qualified'' for 2010. Therefore, one factor in the cost to EHR vendors is the cost associated with completing the self-nomination process in order for the vendor's EHR product(s) to be considered ''qualified.'' Similar to the estimated cost to the registry associated with the registry self-nomination process, the estimated cost for an EHR vendor to complete the self-nomination process, including the vetting process with CMS officials, is conservatively estimated to be $500 ($50 per hour × 10 hours per EHR vendor). Our estimate of a $50 per hour average labor cost for EHR vendors is based on the assumption that EHR vendor staff include IT professionals whose average hourly rates range from $36 to $84 per hour depending on experience, with an average rate of nearly $50 per hour for a mid-level programmer.

Another factor in the cost to EHR vendors is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting 2010 PQRI quality measures. The cost associated with the time and effort needed for an EHR vendor to review the quality measures and other information and program each qualified EHR product to enable eligible professionals to submit PQRI quality measures data to the CMS-designated clinical warehouse will be dependent on the EHR vendor's familiarity with PQRI, the vendor's system capabilities, as well as the vendor's programming capabilities. Some vendors already have these necessary capabilities and for such vendors, we estimate the total cost to be approximately $2,000 ($50 per hour × 40 hours per vendor). However, given the variability in the capabilities of the vendors, we believe a more conservative estimate for those vendors with minimal experience would be approximately $10,000 per vendor ($50 per hour × 200 hours per EHR vendor).

With respect to the process for group practices to be treated as satisfactorily submitting quality measures data under the 2010 PQRI discussed in section II.G.2.g. of this final rule with comment period, group practices interested in participating in the 2010 PQRI through the group practice reporting option must complete a self-nomination process similar to the self-nomination process required of registries and EHR vendors. We estimate that the group practice staff involved in the group practice self-nomination process have an average labor cost of $55 per hour. Therefore, assuming the total burden hours per group practice associated with the group practice self-nomination process is 4 hours, we estimate the total cost to a group practice associated with the group practice self-nomination process to be approximately $220 ($55 per hour × 4 hours per group practice). After considering the comments received, we will also assign an additional 2 hours as the time needed by group practices to review the 2010 PQRI reporting options and make the decision to participate as a group rather than individually. The total costs associated with the decision-making process is estimated to be $110 ($55 per hour × 2 hours per group practice)

The cost associated with the group practice reporting requirements of this voluntary reporting initiative is the time and effort associated with the group practice submitting the quality measures data. For physician group practices, this would be the time associated with the physician group completing the data collection tool. The information collection components of this data collection tool have been reviewed by OMB and are currently approved under OMB control number 0938–0941, with an expiration date of December 31, 2011. Based on cost estimates for the Physician Group Practice (PGP) demonstration, we estimate the cost associated with a physician group completing the data collection tool will be approximately 79 hours per physician group. Therefore, we estimate the total annual burden hours per physician group to be approximately 85 hours (2 hours for decision-making process + 4 hours for self-nomination + 79 hours for data submission). Based on

an average labor cost of $55 per physician group, we estimate the cost per physician group associated with participating in the PQRI group practice reporting option would be $4,675 ($55 per hour × 85 hours per group practice).

3. Section 131(c): Physician Resource Use Measurement and Reporting Program

As discussed in section II.G.3. of this final rule with comment period, section 131(c) of the MIPPA amends section 1848 of the Act by adding subsection (n), which requires the Secretary to establish and implement by January 1, 2009, a Physician Feedback Program using Medicare claims data and other data to provide confidential feedback reports to physicians (and as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to Medicare beneficiaries. If determined appropriate by the Secretary, the Secretary may also include information on quality of care furnished to Medicare beneficiaries by the physician (or group of physicians) in the reports. We anticipate the impact of this section to be negligible for the work completed in the Program to date.

4. Section 132: Incentives for Electronic Prescribing (E-Prescribing)—The E-Prescribing Incentive Program

Section II.G.5. of this final rule with comment period describes the 2010 E-Prescribing Incentive Program. To be considered a successful electronic prescriber in 2010, an eligible professional must meet the requirements in section II.G.5.c. of this final rule with comment period.

We anticipate that the cost impact of the E-Prescribing Incentive Program on the Medicare program will be the cost incurred for maintaining the electronic prescribing measure and its associated code set, and for expanding an existing clinical data warehouse to accommodate registry-based reporting and, potentially, EHR-based reporting for the electronic prescribing measure. We, however, do not anticipate a significant cost impact on the Medicare program since much of this infrastructure had already been established for the PQRI.

Participation in the E-Prescribing Incentive Program by eligible professionals is voluntary and eligible professionals may have different processes for integrating the E-Prescribing Incentive Program into their practices' work flows. Therefore, it is difficult to accurately estimate the impact of the E-Prescribing Incentive Program on eligible professionals. In addition, for eligible professionals who are successful electronic prescribers, some (if not all) of the cost of participating in the E-Prescribing Incentive Program may be offset by the incentive payment earned.

Similar to claims-based reporting for PQRI, one factor in the cost to eligible professionals, for those eligible professionals who choose to report the electronic prescribing measure through claims, is the time and effort associated with eligible professionals determining whether the quality measure is applicable to them, gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims they submit for payment. Since the E-Prescribing Incentive Program consists of only 1 quality measure, we will assign 1 hour as the amount of time needed for eligible professionals to review the electronic prescribing measure and incorporate reporting of the selected measures into their office work flows and an additional hour as the amount of time needed for eligible professionals to select an appropriate reporting mechanism for them. At an average cost of approximately $55 per hour (see section XIII.E.2. above for a discussion of how we arrived at this figure), we estimate the total cost to eligible professionals for reviewing the electronic prescribing measure, incorporating reporting of the selected measures into the office work flows, and selecting an appropriate reporting mechanism to be approximately $110 ($55 per hour × 2 hours).

Another factor in the cost to eligible professionals is the time and effort associated with gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims an eligible professional submits for payment. Information from the PVRP estimates that the time needed to perform all the steps necessary to report 1 measure 1 time (that is, reporting the relevant quality data code(s) for the measure for 1 case) on claims ranges from 15 seconds (0.25 minutes) to over 12 minutes for complicated cases and/or measures, with the median time being 1.75 minutes. With an average practice labor cost of $55 per hour, the cost to eligible professionals to perform all of the steps necessary to report 1 quality measure 1 time on claims ranges from $0.23 in labor time to about $11.00 in labor time for more complicated cases and/or measures. For the median practice, the cost is about $1.44 in labor time per measure. Therefore, we estimate the costs to eligible professionals to perform all the steps necessary to report the electronic prescribing measure once on a claim to be approximately $1.44.

The cost for this requirement will also vary along with the volume of claims on which quality data is reported. Based on our proposal to require an eligible professional to report the electronic prescribing measure for at least 25 instances, we estimate the total annual estimated cost per eligible professional to report the electronic prescribing measure to be $146.00 [($1.44 per measure × 1 measure × 25 cases per measure) + $110].

Because registry-based reporting of the electronic prescribing measure to CMS will be new for 2010 and participation in this reporting initiative is voluntary, it is difficult to accurately estimate how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the registry-based reporting mechanism in CY 2010. We do not anticipate, however, any additional cost for eligible professionals to report data to a registry as we believe that most eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry for other purposes, such reporting data to the registry for the PQRI. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program. Furthermore, the same information has to be reported for the E-Prescribing Incentive Program and for the same number of instances regardless of the reporting mechanism selected by the eligible professional. That is, the eligible professional must report that he or she generated and transmitted at least one prescription electronically for at least 25 eligible patient encounters during the reporting period.

One potential cost to some eligible professionals associated with either claims-based reporting or registry-based reporting would be the cost of purchasing and using an electronic prescribing system. There are currently many commercial packages available for electronic prescribing. The cost to an eligible professional of obtaining and utilizing an electronic prescribing system varies not only by the commercial software package selected but also by the level at which the professional currently employs information technology in his or her practice and the level of training needed. One study indicated that a mid-range complete electronic medical record with electronic prescribing functionality costs $2500 per license with an annual fee of $90 per license for

quarterly updates of the drug database after setup costs while a standalone prescribing, messaging, and problem list system costs $1200 per physician per year after setup costs. Hardware costs and setup fees substantially add to the final cost of any software package. (Corley, S.T. (2003). ''Electronic prescribing: a review of costs and benefits.'' Topics in Health Information Management 24(1): 29–38.). Thus, for the purpose of this impact analysis, we estimate that eligible professionals who opt to purchase a standalone electronic prescribing system would incur an average cost of $1200 per physician per year. Eligible professionals who opt to purchase an EHR with electronic prescribing functionality would incur an average cost of $2500 per license with an annual fee of $90 per license for quarterly updates of the drug database.

Based on our policy to consider only registries qualified to submit quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf for the 2010 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program, we do not anticipate any cost to the registry associated with becoming a registry qualified to submit the electronic prescribing measure for 2010.

The cost associated with the registry-based reporting requirements of this voluntary reporting initiative for the registry will be the time and effort associated with the registry calculating results for the electronic prescribing measure from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on the electronic prescribing quality measure to CMS on behalf of their participants. The time needed for a registry to review the electronic prescribing measure and other information, calculate the measure's results, and submit the measure's results and numerator and denominator data on the measure on their participants' behalf is expected to vary along with the number of eligible professionals reporting data to whom the measure applies. However, we believe that registries already perform many of these activities for their participants since the registries are already required to perform these activities for the PQRI. Since the E-Prescribing Incentive Program consists of only one measure, we believe that the cost associated with the registry reporting the measure's results and numerator and denominator to CMS on behalf of their participants would be minimal.

For EHR-based reporting, the eligible professional must review the electronic prescribing measure, extract the necessary clinical data from his or her qualified EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS will be new for 2010 and participation in this reporting initiative is voluntary, it is difficult to accurately estimate how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the EHR-based reporting mechanism in CY 2010. The cost associated with an eligible professional reviewing the electronic prescribing measure and other information to determine whether the measure is applicable to his or her patients and the services he or she furnishes to them and to review the available reporting mechanisms to select the EHR reporting mechanism is expected to be similar for EHR-based reporting and claims-based reporting (that is, $110 at a rate of $55 per hour). Once the EHR is programmed by the vendor to allow data submission to CMS, the cost to the eligible professional associated with the time and effort to submit data on the electronic prescribing measure should be minimal.

Based on our policy to consider only EHR products qualified for the 2010 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program, there will be no need for EHR vendors to undergo a separate self-nomination process for the E-Prescribing Incentive Program and therefore, no additional cost associated with the self-nomination process.

The cost to the EHR vendor associated with the EHR-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting the 2010 electronic prescribing measure. The time needed for an EHR vendor to review the measure and other information and program each qualified EHR product to enable eligible professionals to submit data on the measure to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with the electronic prescribing measure, the vendor's system capabilities, as well as the vendor's programming capabilities. Since only EHR products qualified for the 2010 PQRI will be qualified for the 2010 E-Prescribing Incentive Program and the E-Prescribing Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable eligible professionals to submit data on the electronic prescribing measure to the CMS-designated clinical data warehouse would be minimal.

With respect to the process for group practices to be treated as successful electronic prescribers under the 2010 E-Prescribing Incentive Program discussed in section II.G.5.e. of this final rule with comment period, a group practice will be required to report the electronic prescribing measure in at least 2,500 instances. Group practices have the same options as individual eligible professionals in terms of the form and manner for reporting the electronic prescribing measure (that is, group practices have the option of reporting the measure through claims, a qualified registry, or a qualified EHR product). The only difference between an individual eligible professional and group practice reporting of the electronic prescribing measure is the number of times a group practice is required to report the electronic prescribing measure. Reporting of the electronic prescribing measure can continue to occur at the individual eligible professional level under the electronic prescribing group practice reporting option. In our analysis of the information, however, we will aggregate all of the information reported by the eligible professionals within the group practice to determine whether the group practice reported the measure a sufficient number of times. For group practices that are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through claims-based reporting of the electronic prescribing measure, we estimate the total annual estimated cost per group practice to be $3,710 [($1.44 per measure × 1 measure × 2,500 cases per measure) + $110].

For group practices that are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through registry-based reporting of the electronic prescribing measure, we do not anticipate any additional burden to report data to a registry as group practices opting for registry-based reporting would more than likely already be reporting data to the registry for other purposes, such as the PQRI. Little, if any, additional data would need to be reported to the registry for

purposes of participation in the 2010 E-Prescribing Incentive Program. However, in addition to the 2 hours estimated for the group practice to review the electronic prescribing measure to determine whether it is applicable to their practice and to review the available reporting mechanisms to select the group practice reporting option, group practices will need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each group practice that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

For group practices that are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through EHR-based reporting of the electronic prescribing measure, once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the group practice associated with submission of data on the electronic prescribing measure should be minimal.

In addition to the burden associated with group practices reporting the electronic prescribing measure, group practices will also be required to self-nominate in order to participate in the 2010 E-Prescribing Incentive Program under the group practice reporting option. Since we are limiting participation in the E-Prescribing Incentive Program group practice reporting option to those group practices selected to participate in the PQRI group practice reporting option, there will be no additional burden associated with the group practice self-nomination process for the E-Prescribing Incentive Program.

5. Section 135: Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services.

As discussed in section II.G.6. of this final rule with comment period, suppliers that provide the TC of advanced diagnostic imaging services will have to be accredited by an approved accreditation organization in order to receive Medicare payment for advanced diagnostic imaging services described in section 1848(b)(4)(B) furnished to beneficiaries. This section of the rule will impact the suppliers that provide the TC of advanced diagnostic imaging services and the organizations that accredit suppliers of such services. Suppliers that provide the TC of advanced diagnostic imaging services will incur costs for becoming accredited. Accreditation organizations will incur costs to accredit suppliers. To estimate the impact on suppliers, we calculate the total cost of accreditation as the sum of accreditation fees and other accreditation costs, and we multiply this cost by the number of providers of care requiring accreditation.

a. Factors Affecting the Cost Impact

According to our Services Tracking and Reporting System (STARS) database for 2008, there are a total of 1,131,115 physicians, IDTFs, and others billing Part B for the TC of advanced diagnostic imaging. This total includes both suppliers and providers that furnish items under Medicare Part B as suppliers.

Currently, there are suppliers accredited by one of three of the nationally recognized accreditation. We anticipate that the following accreditation organizations will seek approval from CMS to accredit suppliers that provide the TC of advanced diagnostic imaging services:

- American College of Radiology;
- Intersocietal Accreditation Commission; and
- The Joint Commission.

b. Accreditation Fees

Fees vary between accreditation organizations and, in general, currently cover all of the following items: application fee, manuals, initial accreditation fee, onsite surveys or other auditing (generally once every 3 years), and travel, when necessary for survey personnel. Accreditation costs also vary by the size of the supplier seeking accreditation, its number of locations, and the number of services it provides. Because of these factors, it is sometimes difficult to compare fees across accreditation organizations. We obtained information on total accreditation fees from the three accreditation organizations that currently accredit suppliers who provide the TC of advanced diagnostic imaging services. Based on all information we obtained, we estimate accreditation fees for each review cycle and modality will be approximately $5,000 for an advanced diagnostic imaging supplier. Because accreditation is for a 3-year period, the estimated average cost per year would be approximately $1,666 per modality.

We recognize that becoming accredited may impose a burden on suppliers that provide the TC of advanced diagnostic imaging services, especially small suppliers. We have attempted to minimize that burden. We have implemented the following options to minimize the burden of accreditation on suppliers, including small businesses:

- *Multiple accreditation organizations:* We expect that more than one accrediting organization will apply to become and be designated as an advanced diagnostic imaging accrediting organization. We believe that selection of more than one accreditation organization will introduce competition resulting in reductions in accreditation costs.
- *Required plan for small businesses:* During the application process we will require accreditation organizations to include a plan that details their methodology to reduce accreditation fees and burden for small or specialty suppliers. This will need to include that the accreditation organization's fees are based on the size of the organization.
- *Reasonable quality standards:* The quality standards that will be used to evaluate the services rendered for each imaging modality are industry standards. Many suppliers that provide the TC of advanced diagnostic imaging services already comply with the standards and have incorporated these practices into their daily operations. We have been told that that those suppliers with private insurance contracts must be accredited, thus our requirements would not be duplicative. It is our belief and has been stated by those suppliers already accredited that compliance with the quality standards will result in more efficient and effective business practices and will assist suppliers in reducing overall costs.

c. Other Accreditation Costs

It is difficult to precisely estimate the costs of preparing for accreditation. We do recognize there is cost to the supplier in order to come into compliance initially and thus prepare for the accreditation survey. This should result in minimal preparation and cost.

d. Additional Considerations

There are at least two important sources of uncertainty in estimating the impact of accreditation on suppliers that provide the TC of advanced diagnostic imaging services. First, our estimates assume that all current suppliers with positive Medicare payments will seek accreditation. We assume that suppliers who currently receive no Medicare allowed charges will choose not to seek

accreditation. It is also possible that many of the suppliers with allowed charges between $1 and $10,000 may decide not to incur the costs of accreditation.

Second, it is unclear what accreditation fees will be in the future. However, we are requiring the accreditation organization to submit their fees that are based on the size of the supplier, or on the amount billed. Our experience with another accreditation program has lead us to believe that the accreditation rates will go up, although minimally, if travel costs continue to rise.

In summary, suppliers of the TC of advanced diagnostic imaging services for which payment is made under the fee schedule established under section 1848(b) of the Act must become accredited by an accreditation organization designated by the Secretary beginning January 1, 2012. In these options, we have attempted to minimize the burden of accreditation on suppliers, which include approving multiple accreditation organizations that consider the small suppliers. Also, the fact that the surveys will be either performed as a desk review or unannounced deletes the time and cost for the accreditation organization in travel, if required.

6. Section 139: Improvements for Medicare Anesthesia Teaching Programs

As discussed in section II.G.7., this final rule with comment period would provide for increased payments under the Medicare PFS for certain cases involving teaching anesthesiologists with anesthesia residents or for teaching CRNAs with student nurse anesthetists. This provision of the MIPPA is anticipated to have a minimal budgetary impact.

7. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions: Cardiac Rehabilitation Services

As described in section II.G.8. of this final rule with comment period, current levels of coverage for CR programs are expected to continue under this rule, and new ICR programs will likely develop and request approval by CMS to receive Medicare payments. Because the payment amount for ICR services under section 144(a) of the MIPPA is higher than for CR services, this expansion of coverage will result in greater costs to the Medicare program. The requirements for ICR programs, also specified in section 144(a) of the MIPPA, are extensive and will likely limit the number of individual ICR program sites that request approval. As a result, significantly fewer ICR programs and ICR program sites than CR programs will function throughout the country; however, we currently do not know how many ICR programs may request approval or how many individual sites may furnish ICR services under an approved program.

We believe that the expansion of coverage for ICR programs will enable beneficiaries to take advantage of more focused and rigorous programs that will more quickly lead to improved cardiovascular health. Having the choice of CR and ICR programs, beneficiaries eligible for coverage will be able to determine the best manner in which to achieve improved cardiovascular health, through traditional CR or more rigorous ICR program. We also expect this expansion of coverage to bring more attention to the importance of cardiac rehabilitation and the extensive benefits these programs provide to beneficiaries. As a result, the number of beneficiaries participating in CR programs may increase. We estimate that the provisions for establishing coverage of cardiac rehabilitation and intensive cardiac rehabilitation programs, as discussed in section II.G.8. of this final rule with comment period, will have a minimal budgetary impact on the Medicare program.

8. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions: Pulmonary Rehabilitation Services

As discussed in section II.G.9. of this final rule with comment period, the implementation of the Medicare pulmonary rehabilitation program will allow Medicare, for the first time, to provide for payment for exercise and other services as part of a comprehensive treatment plan for beneficiaries with moderate to very severe COPD. We believe this program has the potential of not only improving the quality of life for beneficiaries who engage in it, but also reducing Medicare costs in the long range by decreasing the chances of exacerbations and further rehabilitation related to their chronic respiratory disease. We estimate this provision will have a minimal budgetary impact on the Medicare program.

9. Section 144(b): Repeal of Transfer of Title for Oxygen Equipment—Repeal of Transfer of Title for Oxygen Equipment

The revisions pertaining to oxygen and oxygen equipment in section II.G.10. of this final rule reflect changes made by the MIPPA of 2008. Section 1834(a)(5)(F) of the Act limited monthly payments to suppliers furnishing oxygen equipment to 36 months of continuous use. Prior to the MIPPA, at the end of this 36-month period, suppliers were required to transfer title to oxygen equipment to the beneficiary. Section 144(b) of the MIPPA repealed the transfer of title requirement. In its place, section 144(b) amends section 1834(a)(5)(F) of the Act by adding additional payment rules and supplier responsibilities discussed previously in this preamble that apply after the 36 month rental cap.

Based on data from the Small Business Administration (SBA), we estimate that 85 percent of suppliers of the items and services affected by this rule would be defined as small entities with total revenues of $7 million or less in any 1 year. In the case of oxygen and oxygen equipment, it is difficult to estimate the impact of section 144(b) of the MIPPA on small entities and oxygen and oxygen equipment suppliers in general. Nevertheless, we do believe that the net impact on small entities and other suppliers of oxygen and oxygen equipment will be positive rather than negative. This is based on the fact that this change allows suppliers to retain ownership of oxygen equipment in all cases when it is no longer needed by the beneficiary. Prior to this change, suppliers were required to relinquish ownership of oxygen equipment after 36 continuous rental months. While suppliers will be required to continue furnishing the equipment after the 36 month rental period for up to 2 additional years in some cases until the 5 year reasonable useful lifetime of the equipment ends, they will retain ownership of equipment when it is no longer needed and can furnish the equipment to other patients. As explained in more detail below, we estimate that suppliers could potentially receive approximately $58 million per year in payments for furnishing oxygen equipment that is returned to them after the 36 month cap and before the end of the 5 year reasonable useful lifetime. Suppliers in these situations are able to forgo the expense of purchasing new equipment from manufacturers to replace equipment they would have transferred to beneficiaries had the transfer of title requirement not been repealed.

Our data indicates that most beneficiaries who receive stationary oxygen equipment are furnished with a stationary oxygen concentrator. As we have indicated previously, oxygen concentrators require very minimal maintenance and servicing if less than

5 years old, and, as described in more detail below, suppliers will receive an annual payment, beginning 6 months after the end of the 36 month rental cap, for maintenance and servicing of the oxygen concentrator. Therefore, suppliers' costs for maintaining this equipment after the cap should be minimal unless they are furnishing equipment that is older than 5 years, in which case they will probably have received significantly more than 36 monthly rental payments from Medicare or other payers for rental of the equipment. In addition, since approximately 76 percent of Medicare beneficiaries that need oxygen do not use the oxygen equipment for more than 36 months, the changes mandated by section 144(b) of the MIPPA will have no impact on suppliers or beneficiaries in the majority of cases. The 76 percent figure is based on the most recent Medicare data available (see Table 52).

Again, if a beneficiary discontinues use of oxygen after the 36-month rental cap but before the end of the reasonable useful lifetime of the equipment (currently 5 years), the supplier will be able to retrieve the equipment and rent it to another Medicare beneficiary or other customer and receive additional rental payments for the remainder of the equipment's reasonable useful lifetime. It is difficult to estimate the magnitude of this positive impact on suppliers. If the equipment is older than 5 years at the time the 36-month rental cap is reached, the supplier may have already received 24 monthly payments or more from Medicare or other payers for rental of the equipment prior to the start of the most recent 36 month rental payment period for the equipment. Combined with the 36 monthly payments made by Medicare in situations where the cap is reached (24 percent of cases based on current data), this would equal or exceed 60 monthly payments for the equipment. On the other hand, assuming the equipment is brand new at the time it is initially furnished in the 24 percent of cases where the cap is reached, the supplier will only have received 36 monthly payments for the new equipment before the rental cap is reached. However, since the equipment will only be 3 years old at this point, depending on when the beneficiary's medical need for or use of the equipment ends, the supplier will be able to furnish the equipment to other patients for any months remaining in the equipment's 5 year or 60 month reasonable useful lifetime. Table 52 illustrates earnings that the supplier could realize from furnishing oxygen equipment that they would have been required to transfer to the beneficiary prior to the enactment of MIPPA.

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TABLE 52: Potential Earnings of Suppliers Given the Retention of Title to the Oxygen Equipment

Month in the Reasonable Useful Lifetime	Percentage of Beneficiaries Using Oxygen Equipment for this Number of Months	Number of Beneficiaries	Number of Months that Equipment can be Rented to another Beneficiary before the end of the Reasonable Useful Lifetime	Earnings for Supplier for a Given Month
36	24.4%			
37	23.8%	8,288	23	$33,511,396
38	23.1%	5,954	22	$23,025,830
39	22.6%	6,487	21	$23,945,761
40	22.0%	5,923	20	$20,822,401
41	21.5%	5,782	19	$19,310,298
42	21.1%	7,599	18	$24,044,916
43	20.4%	6,095	17	$18,214,092
44	19.9%	5,108	16	$14,366,355
45	19.5%	5,735	15	$15,121,029
46	19.0%	5,750	14	$14,151,521
47	18.5%	5,593	13	$12,782,641
48	18.1%	6,831	12	$14,410,424
49	17.5%	5,813	11	$11,240,241
50	17.0%	4,152	10	$7,298,858
51	16.7%	5,108	9	$8,081,075
52	16.2%	4,371	8	$6,147,566
53	15.9%	4,575	7	$5,629,760
54	15.5%	5,327	6	$5,618,743
55	15.1%	3,917	5	$3,442,857
56	14.7%	4,230	4	$2,974,629
57	14.4%	3,901	3	$2,057,452
58	14.1%	4,058	2	$1,426,720
59	13.7%	3,400	1	$597,680
60+	13.4%	161,146	0	$0
			Five-year Total =	288,222,244
			Annual Total =	57,644,449

The data is from Medicare claims data as arrayed by the CMS Pricing, Data Analysis, and Coding (PDAC) contractor in September 2009. The Medicare claims are from January 1, 2002 thru December 31, 2007. We estimate that there were approximately 1.2 million beneficiaries using oxygen equipment during this time based on our analysis of Medicare data. The earnings are calculated using the 2009 monthly payment amount for oxygen and oxygen equipment of $175.79.

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Again, we understand that oxygen equipment is very durable and should need few repairs in the first 5 years. Therefore, we have determined that any costs suppliers may incur in repairs and service visits would be more than offset by the gains they achieve by retaining ownership of the equipment they can then reuse and by payments received for maintenance and servicing after the cap that are established as a result of this final rule with comment period.

Finally, Medicare program expenditures will increase slightly as a result of the payments for maintenance and servicing after the 36 month rental cap for oxygen concentrators and transfilling equipment. Medicare will make maintenance and servicing payments at 6 month intervals following the 36th month payment rental cap. Through June 30, 2010, the payment for these visits is based on 30 minutes of labor. After June 30, 2010, the payment rate is a reasonable fee not to exceed 10 percent of the purchase price for a stationary oxygen concentrator. The total cost in terms of allowed charges per year is calculated to be about $8 million.

10. Section 152(b): Coverage of Kidney Disease Patient Education Services

The implementation of Medicare coverage of kidney disease patient education services as discussed in section II.G.11. of this final rule with comment period will allow Medicare to provide for payment for kidney disease education services for beneficiaries with Stage IV chronic kidney disease. We believe this program can help patients achieve better understanding of their illness, dialysis modality options, and may help delay the need for dialysis. We believe this program has the potential of improving the quality of life for beneficiaries since they will be better equipped to make informed decisions. We estimate a cost to the Medicare program of approximately $10 million for CY 2010, because the statute limits the number of kidney disease education sessions to 6, as a lifetime maximum.

11. Section 153: Renal Dialysis Provisions

A discussion of the impact of section 153 of the MIPPA is addressed in section V.H. of this regulatory impact analysis in conjunction with the other ESRD provisions of this rule.

12. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen

We anticipate that the proposals related to the compendia discussed in section II.G.13. of this final rule with comment period will have a negligible cost to the Medicare program and to the public. The information that is required to be collected and published on the compendia Web sites is information that is already collected in the normal course of business by the compendia publishers, which all have Web sites. The changes will enable CMS to efficiently implement the provisions of section 182(b) of the MIPPA that require transparent evaluative and conflict of interest policies and practices for current and future listed compendia on and after January 1, 2010.

G. Payment for Covered Outpatient Drugs and Biologicals

1. Average Sales Price (ASP) Issues

The changes discussed in section II.H.1. of this final rule with comment period with respect to payment for covered outpatient drugs and biologicals, are estimated to have no impact on Medicare expenditures as we are not making any change to the AMP/WAMP threshold and the change concerning the immunosuppressive drug period of eligibility is a conforming change to reflect the statute.

2. Competitive Acquisition Program (CAP) Issues

As discussed in section II.H.2., this final rule with comment period finalizes several CAP proposals and updates to regulations, specifically the frequency of drug payment amount updates, changes to the CAP drug list, the geographic area served by the CAP, CAP drug stock at the physician's office, exclusion of CAP sales from ASP calculations, the annual CAP payment amount update mechanism, and updates to proposals made in the 2009 PFS rule. Our changes and refinements may improve compliance, promote program flexibility, improve the quality, and maintain the availability of services for participating CAP physicians. We anticipate that these changes associated with the CAP will not result in significant additional cost savings or increases relative to the ASP payment system for two reasons. First, in 2006 through 2008, the dollar volume of claims paid under the CAP was small compared to the volume of claims paid under section 1847A of the Act, and although we anticipate that the CAP will continue to grow, we do not anticipate a significant change in the proportion of claims paid under these payment systems. Second, because CAP payment amounts are limited to prices calculated under section 1847A of the Act, we expect payment rates for the two programs to remain very similar.

H. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities

The ESRD-related provisions are discussed in sections II.G.11 and II.I. of this final rule with comment period. To understand the impact of the changes affecting payments to different categories of ESRD facilities, it is necessary to compare estimated payments under the current year (CY 2009 payments) to estimated payments under the revisions to the composite rate payment system (CY 2010 payments) as discussed in section II.I. of this final rule with comment period. To estimate the impact among various classes of ESRD facilities, it is imperative that the estimates of current payments and estimates of payments contain similar inputs. Therefore, we simulated payments only for those ESRD facilities that we are able to calculate both current 2009 payments and 2010 payments.

ESRD providers were grouped into the categories based on characteristics provided in the Online Survey and Certification and Reporting (OSCAR) file and the most recent cost report data from the Healthcare Cost Report Information System (HCRIS). We also used the June 2009 update of CY 2008 National Claims History file as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. Due to data limitations, we are unable to estimate current and payments for 42 of the 5186 ESRD facilities that bill for ESRD dialysis treatments.

Table 53 shows the impact of this year's changes to CY 2010 payments to hospital-based and independent ESRD facilities. The first column of Table 53 identifies the type of ESRD provider, the second column indicates the number of ESRD facilities for each type, and the third column indicates the number of dialysis treatments.

The fourth column shows the effect of all changes to the ESRD wage index for CY 2010 as it affects the composite rate payments to ESRD facilities. The fourth column compares aggregate ESRD wage adjusted composite rate payments in CY 2010 to aggregate ESRD wage adjusted

composite rate payments in CY 2009. In CY 2009, ESRD facilities receive 100 percent of the CBSA wage adjusted composite rate and 0 percent of the MSA wage adjusted composite rate, ending a 4-year transition period in which they had received an increasing percent of payments based on the CBSA wage adjusted composite rate. The overall effect to all ESRD providers in aggregate is zero because the CY 2010 ESRD wage index has been multiplied by a wage index BN adjustment factor to comply with the statutory requirement that any wage index revisions be done in a manner that results in the same aggregate amount of expenditures as would have been made without any changes in the wage index.

The fifth column shows the effect of changes to the ESRD wage index in CY 2010 and the effect of the MIPPA provisions on ESRD facilities. Section 153(a) of MIPPA amended section 1881(b)(12)(G) of the Act to revise payments to ESRD facilities. For services furnished on or after January 1, 2010, MIPPA provides a 1 percent increase to the composite rate component of the payment system. The fifth column also reflects the changes in payment based on changes to the wage index from CY 2009 to CY 2010.

The sixth column shows the overall effect of the changes in composite rate payments to ESRD providers including the drug add-on. The overall effect is measured as the percent change between the CY 2010 payments to ESRD facilities with all changes as finalized in this rule and CY 2009 payments to ESRD facilities under current payment policies. These payment amounts are computed by multiplying the wage adjusted composite rate including the drug add-on for each provider times the number of dialysis treatments from the CY 2008 claims. The CY 2010 payments are the wage adjusted composite rate for each provider (with the 15.0 percent drug add-on) times dialysis treatments from CY 2008 claims. The CY 2009 current payments are the wage adjusted composite rate for each provider (with the current 15.2 percent drug add-on) times dialysis treatments from CY 2008 claims.

The overall impact to ESRD providers in aggregate is 0.8 percent as shown in Table 53. Most ESRD facilities will see an increase in payments as a result of the MIPPA provision. While the MIPPA provision includes a 1 percent increase to the ESRD composite rate for services provided on or after January 1, 2009, this 1 percent increase does not apply to the drug add-on to the composite rate. For this reason, the impact of all changes in this final rule with comment period is a 0.8 percent increase for all ESRD providers. Overall, payments to independent ESRD facilities will increase by 0.8 percent and payments to hospital-based ESRD facilities will increase by 1.0 percent.

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TABLE 53: Impact of CY 2010 Changes in Payments to Hospital Based and Independent ESRD Facilities

[Percent change in composite rate payments to ESRD facilities]

1	2	3	4	5	6
	Number Of facilities	Number of Dialysis Treatments (in millions)	Effect of Changes in Wage Index 1/	Effect of Changes in Wage Index and of MIPPA provision/2	Overall Effect of Wage Index MIPPA & Drug Add-on 3/
All Providers	5,144	37.5	0.0%	1.0%	0.8%
Independent	4,580	33.8	0.0%	1.0%	0.8%
Hospital Based	564	3.7	0.2%	1.2%	1.0%
By Facility Size					
Less than 5000 treatments	1,929	5.4	0.1%	1.1%	0.9%
5000 to 9999 treatments	2,014	14.7	0.0%	1.0%	0.8%
Greater than 9999 treatments	1,201	17.4	0.0%	1.0%	0.8%
Type of Ownership					
Profit	4,198	30.8	0.0%	1.0%	0.8%
Nonprofit	946	6.7	0.1%	1.1%	0.9%
By Geographic Location					
Rural	1,120	6.1	0.1%	1.1%	1.0%
Urban	4,024	31.4	0.0%	1.0%	0.8%
By Region					
New England	158	1.3	0.3%	1.3%	1.1%
Middle Atlantic	584	4.7	-0.2%	0.8%	0.7%
East North Central	841	5.8	-0.2%	0.8%	0.6%
West North Central	394	2.0	0.3%	1.3%	1.1%
South Atlantic	1,156	8.5	0.1%	1.1%	0.9%
East South Central	403	2.8	0.1%	1.2%	1.0%
West South Central	707	5.4	-0.1%	0.9%	0.8%
Mountain	291	1.7	0.8%	1.8%	1.7%
Pacific	573	4.8	0.0%	1.0%	0.8%
Puerto Rico & Virgin Islands	37	0.4	-2.4%	-1.4%	-1.6%

Notes: Payments have been adjusted to reflect budget neutrality. CY 2009 includes the MIPPA 1 percent increase and site neutral rates. CY 2009 and CY 2010 both reflect 100 percent CBSA wage adjusted composite rate.

[1] This column shows the overall effect of wage index changes on ESRD providers. Composite rate payments are computed using the final CY 2010 wage indexes which are compared to composite rate payments using the current CY 2009 wage indexes.

[2] This column shows the effect of the changes in the wage indexes and the MIPPA provision which includes a 1 percent increase to the composite rate. This provision is effective for services furnished on or after January 1, 2010.

[3] This column shows the percent change between CY 2010 and CY 2009 composite rate payments to ESRD facilities. The CY 2010 payments include the CY 2010 wage adjusted composite rate, a 1 percent increase due to MIPPA effective 1/1/10 and the drug add-on of 15.0 percent.

The CY 2009 payments include the CY 2009 wage adjusted composite rate, a 1 percent increase and site neutral rates effective 1/1/09 and the drug add-on of 15.2 percent. This column shows the effect of wage index, MIPPA, and drug add-on changes. While the MIPPA provision includes a 1 percent increase to the composite rate, this 1 percent increase does not apply to the drug add-on to the composite rate. The impact of all changes in this final rule is a 0.8 percent increase for all ESRD providers.

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I. Chiropractic Demonstration—Application of Budget Neutrality

As discussed in section II.J. of this final rule with comment period, we are going to recoup the $50 million in expenditures from this demonstration over a 5-year period rather than over a 2-year period. We will recoup $10 million each year through adjustments to the PFS for all chiropractors in CYs 2010 through 2014.

To implement this required BN adjustment, we will reduce the payment amount under the PFS for the chiropractic CPT codes (that is, CPT codes 98940, 98941, and 98942) by approximately 2 percent.

J. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues

The revisions to the conditions of participation (CoP) discussed in section II.K. of this final rule with comment period make technical corrections and update the regulations to reflect current industry standards for respiratory therapists. The revisions to the regulations will clarify the qualifications necessary for respiratory therapists' to continue to qualify to furnish respiratory therapy services to CORF patients. These changes are similar to prior rules and will have no impact on CORFs cost.

K. Physician Self-Referral Provisions

In section II N.1. of this final rule with comment period, we discuss our clarification of the physician stand in the shoes provisions at § 411.354(c)(3)(i). This revision will assist designated health services entities in structuring legitimate compensation arrangements by clarifying that the standard for determining compensation between the parties will be dictated by the language of the exceptions within § 411.355 and § 411.357. Furthermore, like other physician self-referral policies, we anticipate that this clarification will result in savings to the Medicare program by reducing overutilization and anti-competitive business arrangements. However, we cannot gauge with any degree of certainty the extent of these savings to the Medicare program.

L. Durable Medical Equipment Related Issues

1. Damages Process

In section II.O.1. of this final rule with comment period, we establish a one-time process that will only impact those suppliers who were awarded a contract and were potentially damaged by the termination of their supplier contracts by MIPPA. The DMEPOS Competitive Bidding Program that was implemented on July 1st, 2008, awarded contracts to 329 suppliers. The following factors may be considered by a contract supplier before deciding to submit a claim:

- The contract itself stipulated that the contract is subject to any changes to the statute or regulations that affect the Medicare program;
- The contract does not guarantee any amount of business or profits, therefore, an efficient business would not be expected to incur large expenses without any guaranteed increase in business and profits;
- The contract stipulates that CMS shall not pay for any expenses incurred by the supplier for the work performed under the contract other than for payment of Medicare claims authorized pursuant to the contract;
- Upon termination of the contracts by MIPPA, payments reverted back to the fee schedule amount, which was on average 26 percent higher than under the DMEPOS Competitive Bidding Program.
- There is a required responsibility under contract law for a company to take action to mitigate expenses to any stop work order.
- CMS listed the winning suppliers on the Medicare Web site at *http://www.Medicare.gov* in the supplier locator tool, a supplier is allowed to keep any new customers they may have obtained as a result of being listed on the supplier locator tool.

By mentioning the list above, we are not suggesting that there would not be legitimate claims for damages. However, these are factors that a supplier may consider when deciding whether to submit a claim for damages.

Based on these reasons and because there have been so few inquiries or responses to the reference in the MIPPA to damages (fewer than 7 suppliers), we believe that as few as 1 percent of the 329 winning suppliers may make a claim for damages. However, as a high estimate, we would estimate that approximately 76 percent of the suppliers (250) may submit a claim. We anticipate that it will take approximately 3 hours at $34/hour (3 × $34 = $102) for an accountant and a company official to review and gather the necessary documents to file a claim for a total of $25,500 (250 × $102). The hourly accountant rate was based on the Bureau of Labor Statistics data collected for June 2006 which was then adjusted to account for inflation. We estimate that this regulation will not have a large budgetary impact. The total cost range of $408 to $25,500 for potential claims from contract suppliers will not result in expenditures of $133 million or more annually. An analysis of the damage payments that may result would be dependent upon an evaluation of the actual claims once they are received.

2. Grandfathering Process

In section II.O.2. of this final rule with comment period, we are revising the definition of a *grandfathered item* to refer to all rented items within a competitively bid product category that the supplier currently rents. The definition of a *grandfathered item* would avoid confusion, on the part of beneficiaries, regarding rented DME items for which a noncontract supplier may choose to be a grandfathered supplier. Under the revised definition, a noncontract supplier will have to choose to be either a grandfathered supplier for all or for none of the DME rented items within a product category that the supplier currently provides. We believe that it will be easier for beneficiaries to recognize which items a supplier is grandfathering or not grandfathering if the supplier's election concerning grandfathering was made by product category rather than making separate choices for each individual HCPCS code.

We also believe the revision of this definition will have a negligible impact on suppliers as product categories consist of related items routinely provided by suppliers. We are only requiring a supplier to provide those rented items within a product category that the supplier was currently furnishing at the start of the competitive bidding program.

While difficult to estimate, we believe that based on 2008 data, there were approximately 1,850 suppliers in the 9 CBAs, for which we will be doing the Round 1 rebid that rented competitively bid items, on average at different points in time during 2008. Therefore, we are using this number to indicate how many suppliers would be renting a DME competitively bid item at the start of the competitive bid program. We believe some suppliers may decide not to bid because of the cost of bidding and accreditation requirements while other suppliers may not qualify for a contract. Since not all suppliers will be awarded contracts and some may not choose to submit a bid, we estimate that in the worst case scenario there will be 1,450 suppliers that will not be awarded contracts, would be renting DME competitive bid items at the time the program is implemented.

Based on our experience from the competitive bidding demonstrations, of the 1,450 suppliers who are not

awarded a contract, we expect 90 percent or 1,305 of these noncontract suppliers will offer to be grandfathered suppliers (0.90 × 1,450 = 1,305) and 10 percent or 145 (0.10 × 1,450 = 145) of the suppliers will choose not to grandfather. We believe most suppliers will not want to pick up their items before the end of the full rental period.

Based on 2008 data, we estimate that there will be 96,000 beneficiaries who reside in a CBA and are renting competitively bid items from suppliers at the start of the round 1 rebid. Based on the 2007 round 1 of the competitive bidding program, we estimate that there would be 74,880 (96,000 × 0.78 = 74,880) beneficiaries who would be renting items from a noncontract supplier.

a. Notification Requirement for Suppliers That Choose To Grandfather

(1) Notification to CMS

For those suppliers that choose to grandfather (1,305), we estimate that it would take the supplier on average 2 hours to develop the 30-day notification that it is required to send to CMS. We estimate that the cost to the supplier to develop the 30-day notification to CMS would be $89.60 for skilled administrative staff (2 hours × $44.80 per hour). The $44.80 is based on 2009 data from the Bureau of Labor Statistics plus an increase for overhead of 40 percent. We estimate that the cost to the supplier to send the notification to CMS would be $5.51 for clerical staff (0.25 hour to send the notification × $22.02 per hour = $5.51). The $22.02 is based on 2009 data from the Bureau of Labor Statistics plus an increase for overhead of 40 percent. We estimate the cost of supplies necessary to send the notification would be $2.00. The total cost for sending the notification would be $7.51 which includes the cost of clerical staff ($5.51) and supplies ($2.00). The individual costs for all suppliers to notify CMS would be $97.11 ($89.60 for development of the letter + $7.51 for preparing and sending each notification = $97.11). The overall cost for suppliers to notify CMS would be approximately $126,728.55 ($97.11 per supplier × 1,305 suppliers = $126,728.55).

(2) Notification to the Beneficiary

We estimate based on 2008 data, we expect that there will be 74,880 beneficiaries who will have been renting competitive bid items from a noncontract supplier at the start of the round 1 rebid of the CBP. Of the 74,880, we believe that approximately 100 percent of these beneficiaries will accept the offer to continue to rent competitively bid items from the noncontract supplier that offers to be a grandfathered supplier. We believe that the beneficiaries will choose to continue to rent from a grandfathered supplier if given the choice because it would be more convenient, assure continuity of care, and eliminate the need to have equipment taken from their home.

Based upon the number of suppliers and beneficiaries, we estimate that there will be an average of 52 beneficiaries per supplier that was not awarded a contract (74,880 beneficiaries/1,450 suppliers = 52). Therefore, we estimate that each noncontract supplier that chooses to grandfather would send the 30-day notification on average to 52 beneficiaries.

We expect that the cost of developing the 30-day notification to a beneficiary will be equivalent to the cost of developing the 30-day notification to CMS ($89.60 per notification). We also expect the cost of sending the 30-day notification per beneficiary to be equivalent to sending the 30-day notification to CMS ($7.51 per notification). The total costs for the 30-day notification to beneficiaries for suppliers that choose the grandfathering option would be $89.60 for development of the letter, and $7.51 for preparing and sending each notification. To calculate the total cost we multiplied $7.51 × 52 beneficiaries and added the development cost for the letter of $89.60 for a total of $480.12 per supplier. The overall cost for these suppliers to provide the 30-day notification to their beneficiaries will be approximately $626,556.60 ($480.12 per supplier × 1,305 suppliers = $626,556.60).

b. Notification Requirement for Suppliers That Choose Not To Grandfather

(1) 30-day Notification to the Beneficiary

We expect that suppliers who choose not to grandfather will incur costs equivalent to the cost of developing and sending the 30-day notification to a beneficiary by those suppliers that choose to grandfather. The overall cost for all suppliers who choose not to grandfather to provide the 30-day notification to the beneficiary is approximately $69,617.40 ($480.12 total cost per supplier × 145 non-grandfathered suppliers = $69,617.40). The estimate of 145 suppliers not choosing to be grandfathered suppliers represents 10 percent of the total number of noncontract suppliers.

While the cost for the 30-day notification to beneficiaries will be exactly the same for all suppliers, those who choose not to become a grandfathered supplier will also incur the cost of the 10-day and 2-day notification.

(2) 10-day and 2-day Notification

For the 10-day notification to a beneficiary, we estimate the supplier will make at least 1 phone call that would take an average of 15 minutes to discuss that the beneficiary must switch to a contract supplier, the schedule for picking up the current equipment by the noncontract supplier, and the delivery of new equipment by the contract supplier. For the 2-day notification to the beneficiary, we estimate that the supplier will make at least 1 phone call that would take an average of 15 minutes to ensure that all of the arrangements are finalized and to answer any last minute questions. We anticipate that clerical staff will perform both of these tasks.

The estimated cost of the 10-day notification totals $5.51 (.25 of an hour × $22.02 per hour for clerical staff based on the 2009 Bureau of Labor Statistics including overhead = $5.51). The estimated cost of the 2-day notification totals $5.51 (.25 of an hour × $22.02 per hour for clerical staff based on the 2009 Bureau of Labor Statistics including overhead = $5.51). Therefore, the 10-day and 2-day notifications for each supplier will cost approximately $11.02. The total cost for each supplier would be approximately $573.04 ($11.02 × 52 beneficiaries = $573.04). The overall impact for all suppliers to make the 10-day and 2-day notifications will be approximately $83,090.80 (145 suppliers × $573.04 per supplier = $83,090.80).

We anticipate that this process will not place a greater burden on the overall small supplier community. This process is only going to affect those small suppliers that were renting items when the competitive bidding program begins and who did not win a contract. The burden on these suppliers will generally be less because small suppliers will have fewer beneficiaries to furnish notifications to.

As an alternative, we considered relying on suppliers to develop their own schedule for informing beneficiaries regarding grandfathering. This alternative would have left the beneficiaries vulnerable to having equipment removed from the home before new equipment was delivered. The process finalized in this regulation ensures the beneficiaries can make an informed decision about the transition policy that works best for them. The alternative we selected ensures the

beneficiaries will have continued access to medically necessary items and be properly informed about the steps they must take so that their services will not be interrupted.

M. Changes to Allowed and Actual Expenditures for Calculating the Physician Fee Schedule Update

In sections V. and VI. of this final rule with comment period, we described our decision to remove drugs from the calculation of allowed and actual expenditures since the 1996/1997 base year and the SGR rate of increase for future years. While removing physician-administered drugs from allowed and actual expenditures will not change the −21.3 percent physician payment rate update (the −21.2 percent change to the CF accounts for an additional 0.1 percent BN adjustment for changes to the RVUs) for services furnished on or after January 1, 2010, this change reduces the discrepancy between actual and target expenditures. Based on the President's budget, we estimate this proposal will cost $45.4 billion from 2010 to 2014 and $122 billion for 2010 to 2019.

N. Alternatives Considered

This final rule with comment period contains a range of policies, including some provisions related to specific MIPPA provisions. The preceding preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, responds to comments on our proposals, presents rationale for our decisions and, where relevant, alternatives that were considered.

O. Impact on Beneficiaries

There are a number of changes in this final rule with comment period that would have an effect on beneficiaries. In general, we believe these changes, including the refinements of the PQRI with its focus on measuring, submitting, and analyzing quality data, the coding provisions related to the IPPE and consultation services, the changes with respect to telehealth services, the kidney disease patient education, pulmonary rehabilitation and intensive cardiac rehabilitation proposals will have a positive impact and improve the quality and value of care provided to Medicare beneficiaries. Additionally, the grandfathering process for DME suppliers will help ensure that beneficiaries are contacted and informed about this process and the choices they have concerning whether or not to use a grandfathered supplier. Moreover, the notice will help to ensure that beneficiaries do not have necessary DME equipment taken from them unexpectedly by a noncontact supplier.

As explained in more detail subsequently in this section, the regulatory provisions may affect beneficiary liability in some cases. Most changes aggregate in beneficiary liability due to a particular provision would be a function of the coinsurance (20 percent if applicable for the particular provision after the beneficiary has met the deductible). Beneficiary liability would also be impacted by the effect of the aggregate cost (savings) of the provision on the standard calculation of the Medicare Part B premium rate (generally 25 percent of the provision's cost or savings). In 2010, total cost sharing (coinsurance and deductible) per Part B enrollee associated with PFS services is estimated to be $399. In addition, the portion of the 2010 standard monthly Part B premium attributable to PFS services is estimated to be $25.70.

To illustrate this point, as shown in Table 50, the 2009 national payment amount in the non-facility setting for CPT code 99203 (Office/outpatient visit, new), is $91.97 which means that in 2009 a beneficiary is responsible for 20 percent of this amount, or $18.39. Based on this rule, the 2010 national payment amount in the non-facility setting for CPT code 99203, as shown in Table 49, is $76.98 which means that, in 2010, the beneficiary coinsurance for this service would be $15.40.

Policies discussed in this rule, such as the coding changes with respect to the RVUs for IPPE and the changes to consultation services, would similarly impact beneficiaries' coinsurance.

P. Accounting Statement

As required by OMB Circular A–4, in Table 54, we have prepared an accounting statement showing the classification of the expenditures associated with this final rule with comment period. This estimate includes the incurred benefit impact associated with the estimated CY 2010 PFS update based on the 2009 Trustees Report baseline, as well as certain MIPPA provisions. All estimated impacts are classified as transfers.

TABLE 54—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES CY 2010

Category	Transfers
Annualized Monetized Transfers	Estimated decrease in expenditures (from CY 2009 to CY 2010) of $13.3 Billion.
From Whom to Whom?	Federal Government to physicians, other practitioners and providers and suppliers who receive payment under Medicare.
Annualized Monetized Transfers	Estimated increase in expenditures of $110 Million for MIPPA Provisions (sections 102 and 152(b)).
From Whom to Whom?	Federal Government to providers.

In accordance with the provisions of Executive Order 12866, this final rule with comment period was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Physician Referral, Reporting and record keeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping.

42 CFR Part 415

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant programs-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 498

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

■ 1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102, 1834, 1871, and 1893 of the Social Security Act (42 U.S.C. 1302, 1395m, 1395hh, and 1395ddd).

Subpart B—Medical and Other Health Services

■ 2. Section 410.30 is amended by revising paragraph (b) to read as follows:

§ 410.30 Prescription drugs used in immunosuppressive therapy.

* * * * *

(b) *Eligibility.* For drugs furnished on or after December 21, 2000, coverage is available only for prescription drugs used in immunosuppressive therapy, furnished to an individual who received an organ or tissue transplant for which Medicare payment is made, provided the individual is eligible to receive Medicare Part B benefits.

* * * * *

■ 3. Section 410.47 is added to read as follows:

§ 410.47 Pulmonary rehabilitation program: Conditions for coverage.

(a) *Definitions.* As used in this section:

Individualized treatment plan means a written plan established, reviewed, and signed by a physician every 30 days, that describes all of the following:

(i) The individual's diagnosis.

(ii) The type, amount, frequency, and duration of the items and services under the plan.

(iii) The goals set for the individual under the plan.

Medical director means the physician who oversees or supervises the PR program.

Outcomes assessment means a written evaluation of the patient's progress as it relates to the individual's rehabilitation which includes the following:

(i) Beginning and end evaluations, based on patient-centered outcomes, which are conducted by the physician at the start and end of the program.

(ii) Objective clinical measures of effectiveness of the PR program for the individual patient, including exercise performance and self-reported measures of shortness of breath and behavior.

Physician means a doctor of medicine or osteopathy as defined in section 1861(r)(1) of the Act.

Physician-prescribed exercise means physical activity, including aerobic exercise, prescribed and supervised by a physician that improves or maintains an individual's pulmonary functional level.

Psychosocial assessment means a written evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation or respiratory condition.

Pulmonary rehabilitation means a physician-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy.

Supervising physician means a physician that is immediately available and accessible for medical consultations and medical emergencies at all times items and services are being furnished under the PR program.

(b) *Beneficiaries who may be covered.* (1) Medicare covers pulmonary rehabilitation for beneficiaries with moderate to very severe COPD (defined as GOLD classification II, III and IV), when referred by the physician treating the chronic respiratory disease.

(2) Additional medical indications for coverage for pulmonary rehabilitation program services may be established through a national coverage determination (NCD).

(c) *Components.* Pulmonary rehabilitation includes all of the following components:

(1) *Physician-prescribed exercise.* This physical activity includes techniques such as exercise conditioning, breathing retraining, step, and strengthening exercises. Some aerobic exercise must be included in each pulmonary rehabilitation session.

(2) *Education or training.* (i) Education or training closely and clearly related to the individual's care and treatment which is tailored to the individual's needs.

(ii) Education includes information on respiratory problem management and, if appropriate, brief smoking cessation counseling.

(iii) Any education or training prescribed must assist in achievement of individual goals towards independence in activities of daily living, adaptation to limitations and improved quality of life.

(3) *Psychosocial assessment.* The psychosocial assessment must meet the criteria as defined in paragraph (a) of this section and includes:

(i) An assessment of those aspects of an individual's family and home situation that affects the individual's rehabilitation treatment.

(ii) A psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

(4) *Outcomes assessment.* The outcomes assessment must meet the criteria as defined in paragraph (a) of this section.

(5) *Individualized treatment plan.* The individualized treatment plan must be established, reviewed, and signed by a physician, who is involved in the patient's care and has knowledge related to his or her condition, every 30 days.

(d) *Settings.* (1) Medicare Part B pays for a pulmonary rehabilitation in the following settings:

(i) Physician's offices.

(ii) Hospital outpatient settings.

(2) All settings must have the following available for immediate use and accessible at all times:

(i) The necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary (for example, oxygen, cardiopulmonary resuscitation equipment, and defibrillator) to treat chronic respiratory disease.

(ii) A physician must be immediately available and accessible for medical consultations and emergencies at all times when services are being provided under the program. This provision is satisfied if the physician meets the requirements for direct supervision for physician office services at § 410.26 of this subpart and for hospital outpatient services at § 410.27 of this subpart.

(e) *Physician standards.* Medicare Part B pays for pulmonary rehabilitation services for PR programs supervised by a physician who meets the following requirements—

(1) Is responsible and accountable for the pulmonary rehabilitation program, including oversight of the PR staff.

(2) Is involved substantially, in consultation with staff, in directing the progress of the individual in the program including direct patient contact related to the periodic review of his or her treatment plan.

(3) Has expertise in the management of individuals with respiratory pathophysiology, and cardiopulmonary training and/or certification including basic life support.

(4) Is licensed to practice medicine in the State in which the pulmonary rehabilitation program is offered.

(f) *Limitations on coverage: Sessions.* Medicare Part B pays for services provided in connection with a pulmonary rehabilitation exercise

program for up to 36 sessions, no more than two sessions per day. Up to an additional 36 sessions may be approved by the Medicare contractor, based on medical necessity in accordance with section 1862(a)(1)(A) of the Act.

(g) *Effective date.* Coverage for pulmonary rehabilitation program services is effective January 1, 2010.

■ 4. Section 410.48 is added to read as follows:

§ 410.48 Kidney disease education services.

(a) *Definitions.* As used in this section:

Kidney disease patient education services means face-to-face educational services provided to patients with Stage IV chronic kidney disease.

Physician means a physician as defined in section 1861(r)(1) of the Act.

Qualified person means either of the following healthcare entities that meets the qualifications and requirements specified in this section to provide kidney disease patient education services—

(i) One of the following healthcare professionals who furnishes services for which payment may be made under the physician fee schedule:

(A) Physician (as defined in section 1861(r)(1) of the Act).

(B) Physician assistant as defined in section 1861(aa)(5) of the Act and § 410.74 of this subpart).

(C) Nurse practitioner as defined in section 1861(aa)(5) of the Act and § 410.75 of this subpart).

(D) Clinical nurse specialist (as defined in section 1861(aa)(5) of the Act and § 410.76 of this subpart),

(ii)(A) A hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice that is located in a rural area as defined in § 412.64(b)(ii)(C) of this chapter; or

(B) A hospital or critical access hospital that is treated as being rural under § 412.103 of this chapter.

Renal dialysis facility means a unit, which is approved to furnish dialysis service(s) directly to end-stage renal disease (ESRD) patients, as defined in § 405.2102 of this chapter.

Stage IV chronic kidney disease means kidney damage with a severe decrease in glomerular filtration rate (GFR) quantitatively defined by a GFR value of 15–29 ml/min/1.73m^2, using the Modification of Diet in Renal Disease (MDRD) Study formula.

(b) *Covered beneficiaries.* Medicare Part B covers outpatient kidney disease patient education services if the beneficiary meets all of the conditions and requirements of this subpart, including all of the following:

(1) Is diagnosed with Stage IV chronic kidney disease.

(2) Obtains a referral from the physician (as defined in section 1861(r)(1) of the Act) managing the beneficiary's kidney condition.

(c) *Qualified person.* (1) Medicare Part B covers outpatient kidney disease patient education services provided by a qualified person as defined in paragraph (a) of this section and must be able to properly receive Medicare payment under part 424 of this chapter.

(2) A qualified person does not include either of the following:

(i) A hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice if kidney disease patient education services are provided outside of a rural area as defined in § 412.64(b)(ii)(C) of this chapter unless the services are furnished in a hospital or critical access hospital that is treated as being in a rural area under § 412.103 of this chapter.

(ii) A renal dialysis facility, as defined in § 405.2102 of this chapter.

(d) *Standards for content of kidney disease patient education services.* The content of the kidney disease patient education services includes the following:

(1) The management of comorbidities including for the purpose of delaying the need for dialysis which includes, but not limited to, the following topics:

(i) Prevention and treatment of cardiovascular disease.

(ii) Prevention and treatment of diabetes.

(iii) Hypertension management.

(iv) Anemia management.

(v) Bone disease and disorders of calcium and phosphorus metabolism management.

(vi) Symptomatic neuropathy management.

(vii) Impairments in functioning and well-being.

(2) The prevention of uremic complications which includes, but not limited to, the following topics:

(i) Information on how the kidneys work and what happens when the kidneys fail.

(ii) Understanding if remaining kidney function can be protected, preventing disease progression, and realistic chances of survival.

(iii) Diet and fluid restrictions.

(iv) Medication review, including how each medication works, possible side effects and minimization of side effects, the importance of compliance, and informed decision-making if the patient decides not to take a specific drug.

(3) Therapeutic options, treatment modalities, and settings, including a discussion of the advantages and disadvantages of each treatment option and how the treatments replace the kidney, which includes, but not limited to, the following topics:

(i) Hemodialysis, both at home and in-facility.

(ii) Peritoneal dialysis (PD), including intermittent PD, continuous ambulatory PD, and continuous cycling PD, both at home and in-facility.

(iii) All dialysis access options for hemodialysis and peritoneal dialysis.

(iv) Transplantation.

(4) Opportunities for beneficiaries to actively participate in the choice of therapy and be tailored to meet the needs of the individual beneficiary involved which includes, but not limited to, the following topics:

(i) Physical symptoms.

(ii) Impact on family and social life.

(iii) Exercise.

(iv) The right to refuse treatment.

(v) Impact on work and finances.

(vi) The meaning of test results.

(vii) Psychological impact.

(5) Qualified persons must develop outcomes assessments designed to measure beneficiary knowledge about chronic kidney disease and its treatment.

(i) The outcomes assessments serve to assess program effectiveness of preparing the beneficiary to make informed decisions about their healthcare options related to chronic kidney disease.

(ii) The outcomes assessments serve to assess the program's effectiveness in meeting the communication needs of underserved populations, including persons with disabilities, persons with limited English proficiency, and persons with health literacy needs.

(iii) The assessment must be administered to the beneficiary during a kidney disease education session.

(iv) The outcomes assessments must be made available to CMS upon request.

(e) *Limitations for coverage of kidney disease education services.* (1) Medicare Part B makes payment for up to 6 sessions of kidney disease patient education services.

(2) A session is 1 hour long and may be provided individually or in group settings of 2 to 20 individuals who need not all be Medicare beneficiaries.

(f) *Effective date.* Medicare Part B covers kidney disease patient education services for dates of service on or after January 1, 2010.

■ 5. Section 410.49 is added to read as follows:

§ 410.49 Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage.

(a) *Definitions.* As used in this section:

Cardiac rehabilitation (CR) means a physician-supervised program that furnishes physician prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment.

Individualized treatment plan means a written plan tailored to each individual patient that includes all of the following:

(i) A description of the individual's diagnosis.

(ii) The type, amount, frequency, and duration of the items and services furnished under the plan.

(iii) The goals set for the individual under the plan.

Intensive cardiac rehabilitation (ICR) program means a physician-supervised program that furnishes cardiac rehabilitation and has shown, in peer-reviewed published research, that it improves patients' cardiovascular disease through specific outcome measurements described in paragraph (c) of this section.

Intensive cardiac rehabilitation site means a hospital outpatient setting or physician's office that is providing intensive cardiac rehabilitation utilizing an approved ICR program.

Medical director means a physician that oversees or supervises the cardiac rehabilitation or intensive cardiac rehabilitation program at a particular site.

Outcomes assessment means an evaluation of progress as it relates to the individual's rehabilitation which includes all of the following:

(i) Minimally, assessments from the commencement and conclusion of cardiac rehabilitation and intensive cardiac rehabilitation, based on patient-centered outcomes which must be measured by the physician immediately at the beginning of the program and at the end of the program.

(ii) Objective clinical measures of exercise performance and self-reported measures of exertion and behavior.

Physician means a doctor of medicine or osteopathy as defined in section 1861(r)(1) of the Act.

Physician-prescribed exercise means aerobic exercise combined with other types of exercise (that is, strengthening, stretching) as determined to be appropriate for individual patients by a physician.

Psychosocial assessment means an evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation which includes an assessment of those aspects of an individual's family and home situation that affects the individual's rehabilitation treatment, and psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

Supervising physician means a physician that is immediately available and accessible for medical consultations and medical emergencies at all times items and services are being furnished to individuals under cardiac rehabilitation and intensive cardiac rehabilitation programs.

(b) *General rule.* (1) *Covered beneficiary rehabilitation services.* Medicare part B covers cardiac rehabilitation and intensive cardiac rehabilitation program services for beneficiaries who have experienced one or more of the following:

(i) An acute myocardial infarction within the preceding 12 months;

(ii) A coronary artery bypass surgery;

(iii) Current stable angina pectoris;

(iv) Heart valve repair or replacement;

(v) Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting;

(vi) A heart or heart-lung transplant.

(vii) For cardiac rehabilitation only, other cardiac conditions as specified through a national coverage determination.

(2) *Components of a cardiac rehabilitation program and an intensive cardiac rehabilitation program.* Cardiac rehabilitation programs and intensive cardiac rehabilitation programs must include all of the following:

(i) Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished.

(ii) Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to the patients' individual needs.

(iii) Psychosocial assessment.

(iv) Outcomes assessment.

(v) An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

(3) *Settings.* (i) Medicare Part B pays for cardiac rehabilitation and intensive cardiac rehabilitation in one of the following settings:

(A) A physician's office.

(B) A hospital outpatient setting.

(ii) All settings must have a physician immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision for physician office services, at § 410.26 of this subpart; and for hospital outpatient services at § 410.27 of this subpart.

(c) *Standards for an intensive cardiac rehabilitation program.* (1) To be approved as an intensive cardiac rehabilitation program, a program must demonstrate through peer-reviewed, published research that it has accomplished one or more of the following for its patients:

(i) Positively affected the progression of coronary heart disease.

(ii) Reduced the need for coronary bypass surgery.

(iii) Reduced the need for percutaneous coronary interventions;

(2) An intensive cardiac rehabilitation program must also demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in 5 or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services:

(i) Low density lipoprotein.

(ii) Triglycerides.

(iii) Body mass index.

(iv) Systolic blood pressure.

(v) Diastolic blood pressure.

(vi) The need for cholesterol, blood pressure, and diabetes medications.

(3) A list of approved intensive cardiac rehabilitation programs, identified through the national coverage determination process, will be posted to the CMS Web site and listed in the **Federal Register.**

(4) All prospective intensive cardiac rehabilitation sites must apply to enroll as an intensive cardiac rehabilitation program site using the designated forms as specified at § 424.510 of this chapter. For purposes of appealing an adverse determination concerning site approval, an intensive cardiac rehabilitation site is considered a supplier (or prospective supplier) as defined in § 498.2 of this chapter.

(d) *Standards for the physician responsible for cardiac rehabilitation program.* A physician responsible for a cardiac rehabilitation program or intensive cardiac rehabilitation programs is identified as the medical directors. The medical director, in consultation with staff, are involved in directing the progress of individuals in the program, must possess all of the following:

(1) Expertise in the management of individuals with cardiac pathophysiology.

(2) Cardiopulmonary training in basic life support or advanced cardiac life support.

(3) Be licensed to practice medicine in the State in which the cardiac rehabilitation program is offered.

(e) *Standards for supervising-physicians.* Physicians acting as the supervising-physician must possess all of the following:

(1) Expertise in the management of individuals with cardiac pathophysiology.

(2) Cardiopulmonary training in basic life support or advanced cardiac life support.

(3) Be licensed to practice medicine in the State in which the cardiac rehabilitation program is offered.

(f) *Limitations for coverage of cardiac rehabilitation programs.* (1) *Cardiac Rehabilitation:* The number of cardiac rehabilitation program sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 36 weeks with the option for an additional 36 sessions over an extended period of time if approved by the Medicare contractor under section 1862(a)(1)(A) of the Act.

(2) *Intensive Cardiac Rehabilitation:* Intensive cardiac rehabilitation program sessions are limited to 72 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks.

■ 6. Section 410.78 is amended by—

■ A. Revising the introductory text of paragraph (b).

■ B. Revising paragraph (e).

The revisions read as follows:

§ 410.78 Telehealth services.

* * * * *

(b) *General rule.* Medicare Part B pays for office and other outpatient visits, professional consultation, psychiatric diagnostic interview examination, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one visit per month to examine the access site), individual medical nutrition therapy, the neurobehavioral status exam, initial and follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals and SNFs, and individual health and behavior assessment and intervention services furnished by an interactive telecommunications system if the following conditions are met:

* * * * *

(e) *Limitations.* (1) A clinical psychologist and a clinical social worker may bill and receive payment for individual psychotherapy via a telecommunications system, but may not seek payment for medical evaluation and management services.

(2) The physician visits required under § 483.40(c) of this title may not be furnished as telehealth services.

* * * * *

Subpart I—Payment of SMI Benefits

■ 7. Section 410.155 is amended by—

■ A. Revising paragraphs (a), (b)(2)(i), (b)(2)(ii), (b)(2)(iv), (b)(2)(v), and (c).

■ B. Adding paragraph (b)(3).

The revisions and addition read as follows:

§ 410.155 Outpatient mental health treatment limitation.

(a) *Limitation.* For services subject to the limitation as specified in paragraph (b) of this section, the percentage of the expenses incurred for such services during a calendar year that is considered incurred expenses under Medicare Part B when determining the amount of payment and deductible under § 410.152 and § 410.160 of this part, respectively, is as follows:

(1) For expenses incurred in years before 2010, 62½ percent.

(2) For expenses incurred in 2010 and 2011, 68¾ percent.

(3) For expenses incurred in 2012, 75 percent.

(4) For expenses incurred in 2013, 81¼ percent.

(5) For expenses incurred in CY 2014 and subsequent years, 100 percent.

(b) * * *

(2) * * *

(i) Services furnished to a hospital inpatient.

(ii) Brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, or personality disorders *billed under HCPCS code M0064 (or its successor).*

* * * * *

(iv) Psychiatric diagnostic services billed under CPT codes 90801 and 90802 (or successor codes) and diagnostic psychological and neuropsychological tests billed under CPT code range 96101 through 96125 (or successor codes) that are performed to establish a diagnosis.

(v) Medical management such as that furnished under CPT code 90862 (or its successor code), as opposed to psychotherapy, furnished to a patient diagnosed with Alzheimer's disease or a related disorder.

(3) *Payment amounts.* The Medicare payment amount and the patient liability amounts for outpatient mental health services subject to the limitation for each year during which the limitation is phased out are as follows:

Calendar year	Recognized incurred expenses	Patient pays	Medicare pays
CY 2009 and prior calendar years	62.50%	50%	50%
CYs 2010 and 2011	68.75%	45%	55%
CY 2012	75.00%	40%	60%
CY 2013	81.25%	35%	65%
CY 2014	100.00%	20%	80%

(c) *General formula.* A general formula for calculating the amount of Medicare payment and the patient liability for outpatient mental health services subject to the limitation is as follows:

(1) Multiply the Medicare approved amount by the percentage of incurred expenses that is recognized as incurred expenses for Medicare payment purposes for the year involved;

(2) Subtract from this amount the amount of any remaining Part B deductible for the patient and year involved; and,

(3) Multiply this amount by 0.80 (80 percent) to obtain the Medicare payment amount.

(4) Subtract the Medicare payment amount from the Medicare-approved amount to obtain the patient liability amount.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

■ 8. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn).

Subpart J—Financial Relationships Between Physicians and Entities Furnishing Designated Health Services

■ 9. Section 411.354 is amended by revising paragraph (c)(3)(i) to read as follows:

§ 411.354 Financial relationship, compensation, and ownership or investment interest.

* * * * *

(c) * * *

(3)(i) For purposes of paragraphs (c)(1)(ii) and (c)(2)(iv) of this section, a physician who ''stands in the shoes'' of his or her physician organization is deemed to have the same compensation arrangements (with the same parties and on the same terms) as the physician organization. When applying the exceptions in § 411.355 and § 411.357 of this part to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated ''between the parties'' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

■ 10. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(l) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(l)).

Subpart B—Physicians and Other Practitioners

■ 11. Section 414.46 is amended by revising paragraphs (d)(2) and (e) to read as follows:

§ 414.46 Additional rules for payment of anesthesia services.

* * * * *

(d) * * *

(2) The rules for medical direction differ for certain time periods depending on the nature of the qualified individual who is directed by the physician.

(i) If more than two procedures are directed on or after January 1, 1994, the qualified individuals could be AAs, CRNAs, interns, or residents. The medical direction rules apply to student nurse anesthetists only if the physician directs two concurrent cases, each of which involves a student nurse anesthetist or the physician directs one case involving a student nurse anesthetist and the other involving a CRNA, AA, intern, or resident.

(ii) For services furnished on or after January 1, 2010, the medical direction rules do not apply to a single anesthesia resident case that is concurrent to another case which is paid under the medical direction payment rules as specified in paragraph (e) of this section.

* * * * *

(e) *Special payment rule for teaching anesthesiologist involved in a single resident case or two concurrent cases.* For physicians' services furnished on or after January 1, 2010, if the teaching anesthesiologist is involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount must be 100 percent of the fee schedule amount otherwise applicable if the anesthesia services were personally performed by the teaching anesthesiologist and the teaching anesthesiologist fulfilled the criteria in § 415.178 of this chapter. This special payment rule also applies if the teaching anesthesiologist is involved in one resident case that is concurrent to another case paid under the medical direction payment rules.

* * * * *

■ 12. Section 414.61 is added to read as follows:

§ 414.61 Payment for anesthesia services furnished by a teaching CRNA.

(a) *Basis for payment.* Beginning January 1, 2010, anesthesia services furnished by a teaching CRNA may be paid under one of the following conditions:

(1) The teaching CRNA, who is not under medical direction of a physician, is present with the student nurse anesthetist for the pre and post anesthesia services included in the anesthesia base units payment and is continuously present during anesthesia time in a single case with a student nurse anesthetist.

(2) The teaching CRNA, who is not under the medical direction of a physician, is involved with two concurrent anesthesia cases with student nurse anesthetists. The teaching CRNA must be present with the student nurse anesthetist for the pre and post anesthesia services included in the anesthesia base unit. For the anesthesia time of the two concurrent cases, the teaching CRNA can only be involved with those two concurrent cases and may not perform services for other patients.

(b) *Level of payment.* The allowance for the service of the teaching CRNA, furnished under paragraph (a) of this section, is determined in the same way as for a physician who personally performs the anesthesia service alone as specified in § 414.46(c) of this subpart.

■ 13. Section 414.65 is amended by revising paragraph (a)(1) to read as follows:

§ 414.65 Payment for telehealth services.

(a) * * *

(1) The Medicare payment amount for office or other outpatient visits, consultation, individual psychotherapy, psychiatric diagnostic interview examination, pharmacologic management, end-stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site), individual medical nutrition therapy, and individual health and behavior assessment and intervention services furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

(i) *Initial inpatient telehealth consultations.* The Medicare payment amount for initial inpatient telehealth consultations furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable to initial hospital care provided by a physician or practitioner.

(ii) *Follow-up inpatient telehealth consultations.* The Medicare payment amount for follow-up inpatient telehealth consultations furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable to subsequent hospital care provided by a physician or practitioner.

* * * * *

■ 14. Section 414.68 is added to subpart B to read as follows:

§ 414.68 Imaging accreditation.

(a) *Scope and purpose.* Section 1834(e) of the Act requires the Secretary to designate and approve independent accreditation organizations for purposes of accrediting suppliers furnishing the technical component (TC) of advanced diagnostic imaging services and establish procedures to ensure that the criteria used by an accreditation organization is specific to each imaging modality. Suppliers of the TC of advanced diagnostic imaging services for which payment is made under the fee schedule established in section 1848(b) of the Act must become accredited by an accreditation organization designated by the Secretary beginning January 1, 2012.

(b) *Definitions.* As used in this section, the following definitions are applicable:

Accredited supplier means a supplier that has been accredited by a CMS-designated accreditation organization as specified in this part.

Advanced diagnostic imaging service means any of the following diagnostic services:

(i) Magnetic resonance imaging.

(ii) Computed tomography.

(iii) Nuclear medicine.

(iv) Positron emission tomography.

CMS-approved accreditation organization means an accreditation organization designated by CMS to perform the accreditation functions specified in section 1834(e) of the Act.

(c) *Application and reapplication procedures for accreditation organizations.* An independent accreditation organization applying for approval or reapproval of authority to survey suppliers for purposes of accrediting suppliers furnishing the TC of advanced diagnostic imaging services is required to furnish CMS with all of the following:

(1) A detailed description of how the organization's accreditation criteria satisfy the statutory standards authorized by section 1834(e)(3) of the Act, specifically—

(i) Qualifications of medical personnel who are not physicians and who furnish the TC of advanced diagnostic imaging services;

(ii) Qualifications and responsibilities of medical directors and supervising physicians (who may be the same person), such as their training in advanced diagnostic imaging services in a residency program, expertise obtained through experience, or continuing medical education courses;

(iii) Procedures to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by the supplier, including a thorough evaluation of equipment performance and safety;

(iv) Procedures to ensure the safety of persons who furnish the TC of advanced diagnostic imaging services and individuals to whom such services are furnished;

(v) Procedures to assist the beneficiary in obtaining the beneficiary's imaging records on request; and

(vi) Procedures to notify the accreditation organization of any changes to the modalities subsequent to the organization's accreditation decision.

(2) An agreement to conform accreditation requirements to any changes in Medicare statutory requirements authorized by section 1834(e) of the Act. The accreditation organization must maintain or adopt standards that are equal to, or more stringent than, those of Medicare.

(3) Information that demonstrates the accreditation organization's knowledge and experience in the advanced diagnostic imaging arena.

(4) The organization's proposed fees for accreditation for each modality in which the organization intends to offer accreditation, including any plans for reducing the burden and cost of accreditation to small and rural suppliers.

(5) Any specific documentation requirements and attestations requested by CMS as a condition of designation under this part.

(6) A detailed description of the organization's survey process, including the following:

(i) Type and frequency of the surveys performed.

(ii) The ability of the organization to conduct timely reviews of accreditation applications, to include the organizations national capacity.

(iii) Description of the organization's audit procedures, including random site visits, site audits, or other strategies for ensuring suppliers maintain compliance for the duration of accreditation.

(iv) Procedures for performing unannounced site surveys.

(v) Copies of the organization's survey forms.

(vi) A description of the accreditation survey review process and the accreditation status decision-making process, including the process for addressing deficiencies identified with the accreditation requirements, and the procedures used to monitor the correction of deficiencies found during an accreditation survey.

(vii) Procedures for coordinating surveys with another accrediting organization if the organization does not accredit all products the supplier provides.

(viii) Detailed information about the individuals who perform evaluations for the accreditation organization, including all of the following information:

(A) The number of professional and technical staff that are available for surveys.

(B) The education, employment, and experience requirements surveyors must meet.

(C) The content and length of the orientation program.

(ix) The frequency and types of in-service training provided to survey personnel.

(x) The evaluation systems used to monitor the performance of individual surveyors and survey teams.

(xi) The policies and procedures regarding an individual's participation in the survey or accreditation decision process of any organization with which the individual is professionally or financially affiliated.

(xii) The policies and procedures used when an organization has a dispute regarding survey findings or an adverse decision.

(7) Detailed information about the size and composition of survey teams for each category of advanced medical imaging service supplier accredited.

(8) A description of the organization's data management and analysis system for its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

(9) The organization's procedures for responding to and for the investigation of complaints against accredited facilities, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and CMS.

(10) The organization's policies and procedures for the withholding or removal of accreditation status for facilities that fail to meet the accreditation organization's standards or requirements, and other actions taken by the organization in response to noncompliance with its standards and requirements. These policies and procedures must include notifying CMS of Medicare facilities that fail to meet the requirements of the accrediting organization.

(11) A list of all currently accredited suppliers, the type and category of accreditation currently held by each supplier, and the expiration date of each supplier's current accreditation.

(12) A written presentation that demonstrates the organization's ability to furnish CMS with electronic data in ASCII comparable code.

(13) A resource analysis that demonstrates that the organization's staffing, funding, and other resources are adequate to perform the required surveys and related activities.

(14) A statement acknowledging that, as a condition for approval of designation, the organization agrees to carry out the following activities:

(i) Prioritize surveys for those suppliers needing to be accredited by January 1, 2012.

(ii) Notify CMS, in writing, of any Medicare supplier that had its accreditation revoked, withdrawn, revised, or any other remedial or adverse action taken against it by the accreditation organization within 30 calendar days of any such action taken.

(iii) Notify all accredited suppliers within 10 calendar days of the organization's removal from the list of designated accreditation organizations.

(iv) Notify CMS, in writing, at least 30 calendar days in advance of the effective date of any significant proposed changes in its accreditation requirements.

(v) Permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

(vi) Notify CMS, in writing (electronically or hard copy), within 2 business days of a deficiency identified in any accreditation supplier from any source where the deficiency poses an immediate jeopardy to the supplier's beneficiaries or a hazard to the general public.

(vii) Provide, on an annual basis, summary data specified by CMS that relates to the past year's accreditations and trends.

(viii) Attest that the organization will not perform any accreditation surveys of Medicare-participating suppliers with which it has a financial relationship in which it has an interest.

(ix) Conform accreditation requirements to changes in Medicare requirements.

(x) If CMS withdraws an accreditation organization's approved status, work collaboratively with CMS to direct suppliers to the remaining accreditation organizations within a reasonable period of time.

(d) *Determination of whether additional information is needed.* If CMS determines that additional information is necessary to make a determination for approval or denial of the accreditation organization's application for designation, the organization must be notified and afforded an opportunity to provide the additional information.

(e) *Visits to the organization's office.* CMS may visit the organization's offices to verify representations made by the organization in its application, including, but not limited to, reviewing documents and interviewing the organization's staff.

(f) *Formal notice from CMS.* The accreditation organization will receive a formal notice from CMS stating whether the request for designation has been approved or denied. If approval was denied the notice includes the basis for denial and reconsideration and reapplication procedures.

(g) *Ongoing responsibilities of a CMS-approved accreditation organization.* An accreditation organization approved by CMS must carry out the following activities on an ongoing basis:

(1) Provide CMS with all of the following in written format (either electronic or hard copy):

(i) Copies of all accreditation surveys, together with any survey-related information that CMS may require (including corrective action plans and summaries of findings with respect to unmet CMS requirements).

(ii) Notice of all accreditation decisions.

(iii) Notice of all complaints related to suppliers.

(iv) Information about all accredited suppliers against which the accreditation organization has taken remedial or adverse action, including revocation, withdrawal, or revision of the supplier's accreditation.

(v) Notice of any proposed changes in its accreditation standards or requirements or survey process. If the organization implements the changes before or without CMS' approval, CMS may withdraw its approval of the accreditation organization.

(2) Within 30 calendar days after a change in CMS requirements, the accreditation organization must submit an acknowledgment of receipt of CMS' notification to CMS.

(3) The accreditation organization must permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

(4) Within 2 business days of identifying a deficiency of an accredited supplier that poses immediate jeopardy to a beneficiary or to the general public, the accreditation organization must provide CMS with written notice of the deficiency and any adverse action implemented by the accreditation organization.

(5) Within 10 calendar days after CMS' notice to a CMS-approved accreditation organization that CMS intends to withdraw approval of the accreditation organization, the accreditation organization must provide written notice of the withdrawal to all of the organization's accredited suppliers.

(6) The organization must provide, on an annual basis, summary data specified by CMS that relate to the past year's accreditation activities and trends.

(h) *Continuing Federal oversight of approved accreditation organizations.* This paragraph establishes specific criteria and procedures for continuing oversight and for withdrawing approval of a CMS-approved accreditation organization.

(1) *Validation audits.* (i) CMS or its contractor may conduct an audit of an accredited supplier to validate the survey accreditation process of approved accreditation organizations for the TC of advanced diagnostic imaging services.

(ii) The audits must be conducted on a representative sample of suppliers who have been accredited by a particular accrediting organization or in response to allegations of supplier noncompliance with the standards.

(A) When conducted on a representative sample basis, the audit is comprehensive and addresses all of the standards, or may focus on a specific standard in issue.

(B) When conducted in response to an allegation, CMS audits any standards that CMS determines are related to the allegations.

(2) *Notice of intent to withdraw approval.* (i) If, during the audit specified in paragraph (h)(1) of this section, CMS identifies any accreditation programs for which validation audit results indicate—

(A) A 10 percent or greater rate of disparity between findings by the accreditation organization and findings by CMS on standards that do not constitute immediate jeopardy to patient health and safety if unmet; or

(B) Any disparity between findings by the accreditation organization and findings by CMS on standards that constitute immediate jeopardy to patient health and safety if unmet; or,

(C) Irrespective of the rate of disparity, widespread or systemic problems in an organization's accreditation process such that accreditation by that accreditation organization no longer provides CMS with adequate assurance that suppliers meet or exceed the Medicare requirements; then CMS will give the organization written notice of its intent to withdraw approval as specified in paragraph (h)(3) of this section.

(ii) CMS may also provide the organization written notice of its intent to withdraw approval if an equivalency review, onsite observation, or CMS' daily experience with the accreditation organization suggests that the accreditation organization is not meeting the requirements of this section.

(3) *Withdrawal of approval.* CMS may withdraw its approval of an accreditation organization at any time if CMS determines that—

(i) Accreditation by the organization no longer adequately assures that the suppliers furnishing the technical component of advanced diagnostic imaging service are meeting the established industry standards for each modality and that failure to meet those requirements could jeopardize the health or safety of Medicare beneficiaries and could constitute a

significant hazard to the public health; or

(ii) The accreditation organization has failed to meet its obligations with respect to application or reapplication procedures.

(i) *Reconsideration.* An accreditation organization dissatisfied with a determination that its accreditation requirements do not provide or do not continue to provide reasonable assurance that the suppliers accredited by the accreditation organization meet the applicable quality standards is entitled to a reconsideration. CMS reconsiders any determination to deny, remove, or not renew the approval of designation to accreditation organizations if the accreditation organization files a written request for reconsideration by its authorized officials or through its legal representative.

(1) *Filing requirements.* (i) The request must be filed within 30 calendar days of the receipt of CMS notice of an adverse determination or non-renewal.

(ii) The request for reconsideration must specify the findings or issues with which the accreditation organization disagrees and the reasons for the disagreement.

(iii) A requestor may withdraw its request for reconsideration at any time before the issuance of a reconsideration determination.

(2) *CMS response to a filing request.* In response to a request for reconsideration, CMS provides the accreditation organization with—

(i) The opportunity for an informal hearing to be conducted by a hearing officer appointed by the Administrator of CMS and provide the accreditation organization the opportunity to present, in writing and in person, evidence or documentation to refute the determination to deny approval, or to withdraw or not renew designation; and

(ii) Written notice of the time and place of the informal hearing at least 10 business days before the scheduled date.

(3) *Hearing requirements and rules.* (i) The informal reconsideration hearing is open to all of the following:

(A) CMS.

(B) The organization requesting the reconsideration including—

(*1*) Authorized representatives;

(*2*) Technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts); and

(*3*) Legal counsel.

(ii) The hearing is conducted by the hearing officer who receives testimony and documents related to the proposed action.

(iii) Testimony and other evidence may be accepted by the hearing officer even though such evidence may be inadmissible under the Federal Rules of Civil Procedure.

(iv) The hearing officer does not have the authority to compel by subpoena the production of witnesses, papers, or other evidence.

(v) Within 45 calendar days of the close of the hearing, the hearing officer presents the findings and recommendations to the accreditation organization that requested the reconsideration.

(vi) The written report of the hearing officer includes separate numbered findings of fact and the legal conclusions of the hearing officer.

(vii) The hearing officer's decision is final.

Subpart D—Payment for Durable Medical Equipment and Prosthetic and Orthotic Devices

■ 15. Section 414.210 is amended by—

■ A. Revising paragraph (e)(2).

■ B. Adding paragraph (e)(5).

The revision and addition read as follows:

§ 414.210 General payment rules.

* * * * *

(e) * * *

(2) *Maintenance and servicing payment for certain oxygen equipment furnished after the 36-month rental period from January 1, 2009 through June 30, 2010.* The carrier makes a maintenance and servicing payment for oxygen equipment other than liquid and gaseous equipment (stationary and portable) as follows:

(i) For the first 6-month period following the date on which the 36-month rental period ends in accordance with § 414.226(a)(1) of this subpart, no payments are made.

(ii) For each succeeding 6-month period, payment may be made during the first month of that period for 30 minutes of labor for routine maintenance and servicing of the equipment in the beneficiary's home (including an institution used as the beneficiary's home).

(iii) The supplier must visit the beneficiary's home (including an institution used as the beneficiary's home) to inspect the equipment during the first month of the 6-month period.

* * * * *

(5) *Maintenance and servicing payment for certain oxygen equipment furnished after the 36-month rental period and on or after July 1, 2010.* For oxygen equipment other than liquid and gaseous equipment (stationary and portable), the carrier makes payment as follows:

(i) For the first 6-month period following the date on which the 36-month rental period ends in accordance with § 414.226(a)(1) of this subpart, no payments are made.

(ii) For each succeeding 6-month period, payment may be made during the first month of that period for routine maintenance and servicing of the equipment in the beneficiary's home (including an institution used as the beneficiary's home).

(iii) Payment for maintenance and servicing is made based on a reasonable fee not to exceed 10 percent of the purchase price for a stationary oxygen concentrator. This payment includes payment for maintenance and servicing of all oxygen equipment other than liquid or gaseous equipment (stationary or portable).

(iv) The supplier must visit the beneficiary's home (including an institution used as the beneficiary's home) to inspect the equipment during the first month of the 6-month period.

* * * * *

Subpart F—Competitive Bidding for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

■ 16. Section 414.402 is amended by revising the definition ''Grandfathered item'' to read as follows:

§ 414.402 Definitions.

* * * * *

Grandfathered item means all rented items within a product category for which payment was made prior to the implementation of a competitive bidding program to a grandfathered supplier that chooses to continue to furnish the items in accordance with § 414.408(j) of this subpart and that fall within the following payment categories for competitive bidding:

(1) An inexpensive or routinely purchased item described in § 414.220 of this part.

(2) An item requiring frequent and substantial servicing, as described in § 414.222 of this part.

(3) Oxygen and oxygen equipment described in § 414.226 of this part.

(4) Other DME described in § 414.229 of this part.

* * * * *

■ 17. Section 414.408 is amended by—

■ A. Redesignating paragraph (j)(5) as (j)(7).

■ B. Adding new paragraphs (j)(5) and (j)(6).

■ C. Revising paragraph (k)(2).

The additions and revision read as follows:

§ 414.408 Payment rules.

* * * * *

(j) * * *

(5) *Notification of beneficiaries and CMS by suppliers that choose to become grandfathered suppliers.* (i) *Notification of beneficiaries by suppliers.* (A) *Requirements of notification.* A noncontract supplier that elects to become a grandfathered supplier must provide a 30-day written notification to each Medicare beneficiary that resides in a competitive bidding area and is currently renting a competitively bid item from that supplier. The 30-day notification to the beneficiary must meet the following requirements:

(*1*) Be sent by the supplier to the beneficiary at least 30 business days before the start date of the implementation of the competitive bidding program for the CBA in which the beneficiary resides.

(*2*) Identify the grandfathered items that the supplier is willing to continue to rent to the beneficiary.

(*3*) Be in writing (for example, by letter or postcard) and the supplier must maintain proof of delivery.

(*4*) State that the supplier is willing to continue to furnish certain rented Durable Medical Equipment (DME), oxygen and oxygen equipment, and supplies that the supplier is currently furnishing to the beneficiary (that is, before the start of the competitive bidding program) and is willing to continue to provide these items to the beneficiary for the remaining rental months.

(*5*) State that the beneficiary has the choice to continue to receive a grandfathered item(s) from the grandfathered supplier or may elect to receive the item(s) from a contract supplier after the end of the last month for which a rental payment is made to the noncontract supplier.

(*6*) Provide the supplier's telephone number and instruct the beneficiary to call the supplier with any questions and to notify the supplier of his or her decision to use or not use the supplier as a grandfathered supplier.

(*7*) State that the beneficiary can obtain information about the competitive bidding program by calling 1–800–MEDICARE or on the Internet at *http://www.Medicare.gov*.

(B) *Record of beneficiary's choice.* The supplier should obtain an election from the beneficiary regarding whether to use or not use the supplier as a grandfathered supplier. The supplier must maintain a record of its attempts to communicate with the beneficiary to obtain the beneficiary's election regarding grandfathering. When the supplier obtains such an election, the supplier must maintain a record of the beneficiary decision including the date the choice was made, and how the beneficiary communicated his or her choice to the supplier.

(C) *Notification.* If the beneficiary chooses not to continue to receive a grandfathered item(s) from their current supplier, the supplier must provide the beneficiary with 2 more notices in addition to the 30-day notice prior to the supplier picking up its equipment.

(*1*) *10-day notification:* Ten business days prior to picking up the item, the supplier should have direct contact (for example, a phone call) with the beneficiary or the beneficiary's caregiver and receive acknowledgement that the beneficiary understands their equipment will be picked up. This should occur on the first anniversary date after the start of the CBP or on another date agreed to by the beneficiary or the beneficiary's caregiver. The beneficiary's anniversary date occurs every month and is the date of the month on which the item was first delivered to the beneficiary by the current supplier. When a date other than the anniversary date is chosen by the beneficiary or the beneficiary's caregiver, the noncontract supplier will still receive payment up to the anniversary date after the start of the CBP, and the new contract supplier may not bill for any period of time before the anniversary date.

(*2*) *2-day notification:* Two business days prior to picking up the item the supplier should contact the beneficiary or the beneficiary's caregiver by phone to notify the beneficiary of the date the supplier will pick up the item. This date should not be before the beneficiary's first anniversary date that occurs after the start of the competitive bidding program unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(D) *Pickup procedures.* (*1*) The pickup of the noncontract supplier's equipment and the delivery of the new contract supplier's equipment should occur on the same date, that is, the first rental anniversary date of the equipment that occurs after the start of the competitive bidding program unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(*2*) Under no circumstance should a supplier pick up a rented item prior to the supplier's receiving acknowledgement from the beneficiary that the beneficiary is aware of the date on which the supplier is picking up the item and the beneficiary has made arrangements to have the item replaced on that date by a contract supplier.

(*3*) When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary.

(*4*) The contract supplier may not submit a claim with a date of delivery for the new equipment that is prior to the first anniversary date that occurs after the beginning of the CBP, and the contract supplier may not begin billing until the first anniversary date that occurs after the beginning of the CBP.

(*5*) The noncontract supplier must submit a claim to be paid up to the first anniversary date that occurs after the beginning of the CBP. Therefore, they should not pick up the equipment before that date unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(ii) *Notification to CMS by suppliers.* A noncontract supplier that elects to become a grandfathered supplier must provide a written notification to CMS of this decision. This notification must meet the following requirements:

(A) State that the supplier agrees to continue to furnish certain rented DME, oxygen and oxygen equipment that it is currently furnishing to beneficiaries (that is, before the start of the competitive bidding program) in a CBA and will continue to provide these items to these beneficiaries for the remaining months of the rental period.

(B) Include the following information:

(*1*) Name and address of the supplier.

(*2*) The 6-digit NSC number of the supplier.

(*3*) Product category(s) by CBA for which the supplier is willing to be a grandfathered supplier.

(C) State that the supplier agrees to meet all the terms and conditions pertaining to grandfathered suppliers.

(D) Be provided by the supplier to CMS in writing at least 30 business days before the start date of the implementation of the Medicare DMEPOS Competitive Bidding Program.

(6) *Suppliers that choose not to become grandfathered suppliers.* (i) *Requirement for non-grandfathered supplier.* A noncontract supplier that elects not to become a grandfathered supplier is required to pick up the item it is currently renting to the beneficiary from the beneficiary's home after proper notification.

(ii) *Notification.* Proper notification includes a 30-day, a 10-day, and a 2-day notice of the supplier's decision not to become a grandfathered supplier to its Medicare beneficiaries who are

currently renting certain DME competitively bid item(s) and who reside in a CBA.

(iii) *Requirements of notification.* These notifications must meet all of the requirements listed in paragraph (j)(5)(i) of this section for the 30-day, 10-day and 2-day notices that must be sent by suppliers who decide to be grandfathered suppliers, with the following exceptions for the 30-day notice.

(A) State that, for those items for which the supplier has decided not to be a grandfathered supplier, the supplier will only continue to rent these competitively bid item(s) to its beneficiaries up to the first anniversary date that occurs after the start of the Medicare DMEPOS Competitive Bidding Program.

(B) State that the beneficiary must select a contract supplier for Medicare to continue to pay for these items.

(C) Refer the beneficiary to the contract supplier locator tool on and to 1–800–MEDICARE to obtain information about the availability of contract suppliers for the beneficiary's area.

(iv) *Pickup procedures.* (A) The pick-up of the noncontract supplier's equipment and the delivery of the new contract supplier's equipment should occur on the same date, that is, the first rental anniversary date of the equipment that occurs after the start of the competitive bidding program unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(B) Under no circumstance should a supplier pick up a rented item prior to the supplier's receiving acknowledgement from the beneficiary that the beneficiary is aware of the date on which the supplier is picking up the item and the beneficiary has made arrangements to have the item replaced on that date by a contract supplier.

(C) When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are agreeable to the beneficiary.

(D) The contract supplier cannot submit a claim with a date of delivery for the new equipment that is prior to the first anniversary date that occurs after the beginning of the CBP.

* * * * *

(k) * * *

(2) Additional payments are made in accordance with § 414.210(e)(2), (e)(3) and (e)(5) of this part for the maintenance and servicing of oxygen equipment if performed by a contract supplier or a noncontract supplier having a valid Medicare billing number.

* * * * *

■ 18. Section 414.425 is added to read as follows:

§ 414.425 Claims for damages.

(a) *Eligibility for filing a claim for damages as a result of the termination of supplier contracts by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).*

(1) Any aggrieved supplier, including a member of a network that was awarded a contract for the Round 1 Durable Medical Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP) that believes it has been damaged by the termination of its competitive bid contract, may file a claim under this section.

(2) A subcontractor of a contract supplier is not eligible to submit a claim under this section.

(b) *Timeframe for filing a claim.* (1) A completed claim, including all documentation, must be filed within 90 days of January 1, 2010 (the effective date of these damages provisions), unless that day is a Federal holiday or Sunday in which case it will fall to the next business day.

(2) The date of filing is the actual date of receipt by the CBIC of a completed claim that includes all the information required by this rule.

(c) *Information that must be included in a claim.* (1) Supplier's name, name of authorized official, U.S. Post Office mailing address, phone number, email address and bidding number, and National Supplier Clearinghouse Number;

(2) A copy of the signed contract entered into with CMS for the Round 1 DMEPOS Competitive Bidding Program;

(3) A detailed explanation of the damages incurred by this supplier as a direct result of the termination of the Round 1 competitive bid contract by MIPPA. The explanation must include all of the following:

(i) Documentation of the supplier's damages through receipts.

(ii) Records that substantiate the supplier's damages and demonstrate that the damages are directly related to performance of the Round 1 contract and are consistent with information the supplier provided as part of their bid.

(4) The supplier must explain how it would be damaged if not reimbursed.

(5) The claim must document steps the supplier took to mitigate any damages they may have incurred due to the contract termination, including a detailed explanation of the steps of all attempts to use for other purposes, return or dispose of equipment or other assets purchased or rented for the use in the Round 1 DMEPOS CBP contract performance.

(d) *Items that will not be considered in a claim.* The following items will not be considered in a claim:

(1) The cost of submitting a bid.

(2) Any fees or costs incurred for consulting or marketing.

(3) Costs associated with accreditation or licensure.

(4) Costs incurred before March 20, 2008.

(5) Costs incurred for contract performance after July 14, 2008 except for costs incurred to mitigate damages.

(6) Any profits a supplier may have expected from the contract.

(7) Costs that would have occurred without a contract having been awarded.

(8) Costs for items such as inventory, delivery vehicles, office space and equipment, personnel, which the supplier did not purchase specifically to perform the contract.

(9) Costs that the supplier has recouped by any means, and may include use of personnel, material, suppliers, or equipment in the supplier's business operations.

(e) *Filing a claim.* (1) A claim, with all supporting documentation, must be filed with the CMS Competitive Bidding Implementation Contractor (CBIC).

(2) Claims must include a statement from a supplier's authorized official certifying the accuracy of the information provided on the claim and all supporting documentation.

(3) The CBIC does not accept electronic submissions of claims for damages.

(f) *Review of claim.* (1) *Role of the CBIC.* (i) The CBIC will review the claim to ensure it is submitted timely, complete, and by an eligible claimant. When the CBIC identifies that a claim is incomplete or not filed timely, it will make a recommendation to the Determining Authority not to process the claim further. Incomplete or untimely claims may be dismissed by the Determining Authority without further processing.

(ii) For complete, timely claims, the CBIC will review the claim on its merits to determine if damages are warranted and may seek further information from the claimant when making its recommendation to the Determining Authority. The CBIC may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.

(iii) The CBIC will make a recommendation to the Determining Authority for each claim filed and

include an explanation that supports its recommendation.

(iv) The recommendation must be either to award damages for a particular amount (which may not be the same amount requested by the claimant) or that no damages should be awarded.

(A) If the CBIC recommends that damages are warranted, the CBIC will calculate a recommended reasonable amount of damages based on the claim submitted.

(B) The reasonable amount will consider both costs incurred and the contractor's attempts and action to limit the damages;

(v) The recommendation will be sent to the Determining Authority for a final determination.

(2) *CMS' role as the Determining Authority.* (i) The Determining Authority shall review the recommendation of the CBIC.

(ii) The Determining Authority may seek further information from the claimant or the CBIC in making a concurrence or non-concurrence determination.

(iii) The Determining Authority may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.

(iv) If the Determining Authority concurs with the CBIC recommendation, the Determining Authority shall submit a final signed decision to the CBIC and direct the CBIC to notify the claimant of the decision and the reasons for the final decision.

(v) If the Determining Authority non-concurs with the CBIC recommendation, the Determining Authority may return the claim for further processing or the Determining Authority may:

(A) Write a determination granting (in whole or in part) a claim for damages or denying a claim in its entirety;

(B) Direct the CBIC to write said determination for the Determining Authority's signature; or

(C) Return the claim to the CBIC with further instructions.

(vi) The Determining Authority's determination is final and not subject to administrative or judicial review.

(g) *Timeframe for determinations.* (1) Every effort will be made to make a determination within 120 days of initial receipt of the claim for damages by the CBIC or the receipt of additional information that was requested by the CBIC, whichever is later.

(2) In the case of more complex cases, or in the event of a large workload, a decision will be issued as soon as practicable.

(h) *Notification to claimant of damage determination.* The CBIC must mail the Determining Authority's determination to the claimant by certified mail return receipt requested, at the address provided in the claim.

Subpart H—Fee Schedule for Ambulance Services

■ 19. Section 414.610 is amended by revising paragraph (c)(5)(i) to read as follows:

§ 414.610 Basis of payment.

* * * * *

(c) * * *

(5) * * *

(i) For ground ambulance services where the point of pickup is in a rural area, the mileage rate is increased by 50 percent for each of the first 17 miles and, for services furnished before January 1, 2004, by 25 percent for miles 18 through 50. The standard mileage rate applies to every mile over 50 miles and, for services furnished after December 31, 2003, to every mile over 17 miles. For air ambulance services where the point of pickup is in a rural area, the total payment is increased by 50 percent; that is, the rural adjustment factor applies to the sum of the base rate and the mileage rate.

* * * * *

Subpart J—Submission of Manufacturer's Average Sales Price Data

■ 20. Section 414.802 is amended by revising the definition of ''unit'' to read as follows:

§ 414.802 Definitions.

* * * * *

Unit means the product represented by the 11-digit National Drug Code. The method of counting units excludes units of CAP drugs (as defined in § 414.902 of this part) sold to an approved CAP vendor (as defined in § 414.902 of this part) for use under the CAP (as defined in § 414.902 of this part).

Subpart K—Payment for Drugs and Biologicals Under Part B

§ 414.904 [Amended]

■ 21. Amend § 414.904(d)(3) by removing the phrase ''and 2009'' and adding in its place the phrase ''2009, and 2010.''

■ 22. Section 414.906 is amended by—

■ A. Adding the introductory text to paragraph (c).

■ B. Revising paragraph (c)(1).

■ C. Redesignating paragraph (c)(2) as (c)(3).

■ D. Adding new paragraph (c)(2).

■ E. Adding a paragraph heading to newly designated paragraph (c)(3).

■ F. Adding paragraphs (f)(2)(v), (f)(3)(iv), and (g).

The revision and additions read as follows:

§ 414.906 Competitive acquisition program as the basis for payment.

* * * * *

(c) *Computation of payment amount.* Except as specified in paragraph (c)(2) of this section, payment for CAP drugs is based on bids submitted as a result of the bidding process as described in § 414.910 of this subpart.

(1) *Single payment amount.* (i) A single payment amount for each CAP drug in the competitive acquisition area is determined on the basis of the bids submitted and accepted and updated from the bidding period to the beginning of the payment year.

(ii) The single payment amount is then updated quarterly based on the approved CAP vendor's reasonable net acquisition costs for that category as determined by CMS, and limited by the weighted payment amount established under section 1847A of the Act across all drugs for which a composite bid is required in the category.

(iii) The payment amount for each other drug for which the approved CAP vendor submits a bid in accordance with § 414.910 of this subpart and each other drug that is approved by CMS for the approved CAP vendor to furnish under the CAP is also updated quarterly based on the approved CAP vendor's reasonable net acquisition costs for each HCPCS code and limited by the payment amount established under section 1847A of the Act.

(2) *Updates to payment amount.* (i) The first update is effective on the first day of claims processing for the first quarter of an approved CAP vendor's contract. The first quarterly contract update is based on the reasonable net acquisition cost (RNAC) data reported to CMS or its designee for any purchases of drug before the beginning of CAP claims processing for the contract period and reported to CMS no later than 30 days before the beginning of CAP claims processing.

(ii) For subsequent quarters, each approved CAP vendor must report to CMS or its designee RNAC data for a quarter of CAP drug purchases within 30 days of the close of that quarter.

(iii) For all quarters, only RNAC data from approved CAP vendors that are supplying CAP drugs under their CAP contract at the time updates are being calculated must be used to calculate updated CAP payment amounts.

(iv) CMS excludes such RNAC data submitted by an approved CAP vendor if, during the time calculations are being

done, CMS knows that the approved CAP vendor will not be under contract for the applicable quarterly update.

(v) The payment amount weights must be calculated based on the more recent of the following:

(A) Contract bidding weights.

(B) CAP claims data.

(vi) The payment limit must be determined using the most recent payment limits available to CMS under section 1847A of the Act.

(vii) The following payment amount update calculation must be applied for the group of all drugs for which a composite bid is required.

(A) The most recent previous composite payment amount for the group is updated by—

(*1*) Calculating the percent change in reasonable net acquisition costs for each approved CAP vendor;

(*2*) Calculating the median of all participating approved CAP vendors' adjusted CAP payment amounts; and

(*3*) Limiting the payment as described in paragraph (c)(1) of this section.

(B) The median percent change, subject to the limit described in paragraph (c)(1) of this section, must be the update percentage for that quarter.

(C) The single update percentage must be applied to the payment amount for each drug in the group of drugs for which a composite bid is required in the category.

(viii) The following payment amount update calculation must be applied for each of the following items: Each HCPCS code not included in the composite bid list; Each HCPCS code added to the drug list during the contract period; and each drug that has not yet been assigned a HCPCS code, but for which a HCPCS code will be established.

(A) The most recent previous payment amount for each drug must be updated by calculating the percent change in reasonable net acquisition costs for each approved CAP vendor, then calculating the median of all participating approved CAP vendors' adjusted CAP payment amounts.

(B) The median percent change calculated for each drug, subject to the limit described in paragraph (c)(1) of this section, must be applied to the payment amount for each drug.

(3) *Alternative payment amount.*

* * *

* * * * *

(f) * * *

(2) * * *

(v) On or after January 1, 2010, the proposed addition of drugs with similar therapeutic uses to drugs already supplied under the CAP by the approved CAP vendor(s).

(3) * * *

(iv) In the case of additions requested under paragraph (f)(2)(v) of this section, address and document the need for such an expansion based on demand for the product(s).

* * * * *

(g) *Deletion of drugs on an approved CAP vendor's CAP drug list.* Deletion of drugs on an approved CAP vendor's CAP drug list due to unavailability requires a written request and approval as described in paragraphs (f)(3)(i) through (iii) and (f)(4) of this section.

■ 23. Section 414.908 is amended by revising paragraph (a)(3)(xii) to read as follows:

§ 414.908 Competitive acquisition program.

(a) * * *

(3) * * *

(xii) Agrees not to transport CAP drugs from one practice location or place of service to another location except in accordance with a written agreement between the participating CAP physician and the approved CAP vendor that requires that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported.

* * * * *

■ 24. Section 414.914 is amended by revising paragraph (f)(12) to read as follows:

§ 414.914 Terms of contract.

* * * * *

(f) * * *

(12) Supply CAP drugs upon receipt of a prescription order to all participating CAP physicians who have selected the approved CAP vendor, except when the conditions of paragraph (h) of this section or § 414.916(b) of this subpart are met;

* * * * *

■ 25. Section 414.916 is amended by—

■ A. Redesignating paragraph (b)(4) as (b)(5).

■ B. Adding new paragraph (b)(4).

The addition reads as follows:

§ 414.916 Dispute resolution for vendors and beneficiaries.

* * * * *

(b) * * *

(4) Upon notification from CMS of a participating CAP physician's suspension from the program, the approved CAP vendor must cease delivery of CAP drugs to the suspended participating CAP physician until the suspension has been lifted.

* * * * *

■ 26. Section 414.917 is amended by revising paragraph (b)(4) to read as follows:

§ 414.917 Dispute resolution and process for suspension or termination of approved CAP contract and termination of physician participation under exigent circumstances.

* * * * *

(b) * * *

(4) The approved CAP vendor may appeal that termination by requesting a reconsideration. A determination must be made as to whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. The approved CAP vendor's contract will remain suspended during the reconsideration process.

* * * * *

■ 27. Section 414.930 is amended by—

■ A. Revising paragraph (a).

■ B. Redesignating paragraph (b)(1)(v) as paragraph (b)(1)(vi).

■ C. Adding new paragraph (b)(1)(v).

The revision and addition read as follows:

§ 414.930 Compendia for determination of medically-accepted indications for off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen.

(a) *Definitions.* For the purposes of this section:

Compendium means a comprehensive listing of FDA-approved drugs and biologicals or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example a compendium of anti-cancer treatment. A compendium—

(i) Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases.

(ii) Is indexed by drug or biological.

(iii) Has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.

Publicly transparent process for evaluating therapies means that the process provides that the following information from an internal or external request for inclusion of a therapy in a compendium are available to the public for a period of not less than 5 years, which includes availability on the compendium's Web site for a period of not less than 3 years, coincident with the compendium's publication of the related recommendation:

(i) The internal or external request for listing of a therapy recommendation including criteria used to evaluate the request.

(ii) A listing of all the evidentiary materials reviewed or considered by the compendium pursuant to the request.

(iii) A listing of all individuals who have substantively participated in the review or disposition of the request.

(iv) Minutes and voting records of meetings for the review and disposition of the request.

Publicly transparent process for identifying potential conflicts of interests means that process provides that the following information is identified and made timely available in response to a public request for a period of not less than 5 years, coincident with the compendium's publication of the related recommendation:

(i) Direct or indirect financial relationships that exist between individuals or the spouse or minor child of individuals who have substantively participated in the development or disposition of compendia recommendations and the manufacturer or seller of the drug or biological being reviewed by the compendium. This may include, for example, compensation arrangements such as salary, grant, contract, or collaboration agreements between individuals or the spouse or minor child of individuals who have substantively participated in the review and disposition of the request and the manufacturer or seller of the drug or biological being reviewed by the compendium.

(ii) Ownership or investment interests between individuals or the spouse or minor child of individuals who have substantively participated in the development or disposition of compendia recommendations and the manufacturer or seller of the drug or biological being reviewed by the compendium.

(b) * * *

(1) * * *

(v) Considers whether the publication that is the subject of the request meets the definition of a compendium in this section.

* * * * *

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

■ 28. The authority citation for part 415 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart D—Physician Services in Teaching Settings

■ 29. Section 415.178 is revised to read as follows:

§ 415.178 Anesthesia services.

(a) *General rule.* (1) *For services furnished prior to January 1, 2010*, an unreduced physician fee schedule payment may be made if a physician is involved in a single anesthesia procedure involving an anesthesia resident. In the case of anesthesia services, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. The teaching physician cannot receive an unreduced fee if he or she performs services involving other patients during the period the anesthesia resident is furnishing services in a single case. Additional rules for payment of anesthesia services involving residents are specified in § 414.46(c)(1)(iii) of this chapter.

(2) *For services furnished on or after January 1, 2010*, payment made under § 414.46(e) of this chapter if the teaching anesthesiologist (or different teaching anesthesiologists in the same anesthesia group practice) is present during all critical or key portions of the anesthesia service or procedure involved; and the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.

(b) *Documentation.* Documentation must indicate the teaching physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

■ 30. The authority citation for part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart B—Conditions of Participation: Comprehensive Outpatient Rehabilitation Facilities

■ 31. Section 485.70 is amended by revising paragraph (j) to read as follows:

§ 485.70 Personnel qualifications.

* * * * *

(j) A respiratory therapist must complete one the following criteria:

(1) *Criterion 1.* All of the following must be completed:

(i) Be licensed by the State in which practicing, if applicable.

(ii) Have successfully completed a nationally-accredited educational program for respiratory therapists.

(iii)(A) Be eligible to take the registry examination administered by the National Board for Respiratory Care for respiratory therapists; or

(B) Have passed the registry examination administered by the National Board for Respiratory Care for respiratory therapists.

(2) *Criterion 2:* All of the following must be completed:

(i) Be licensed by the State in which practicing, if applicable.

(ii) Have equivalent training and experience as determined by the National Board for Respiratory Care.

* * * * *

PART 498—APPEALS PROCEDURES FOR DETERMINATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMINATIONS THAT AFFECT THE PARTICIPATION OF ICFs/MR AND CERTAIN NFs IN THE MEDICAID PROGRAM

■ 32. The authority citation for part 498 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—General Provisions

■ 33. Section 498.2 is amended by adding paragraph (13) to the definition of ''supplier'' to read as follows:

§ 498.2 Definitions.

* * * * *

Supplier * * *

(13) A site approved by CMS to furnish intensive cardiac rehabilitation services.

Authority: Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program.

Dated: October 26, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: October 29, 2009.

Kathleen Sebelius,

Secretary.

Note: These addenda will not appear in the Code of Federal Regulations.

Addendum A: Explanation and Use of Addendum B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2010. Addendum

B contains the RVUs for work, non-facility practice expense (PE), facility PE, and malpractice expense, and other information for all services included in the PFS.

In previous years, we have listed many services in Addendum B that are not paid under the PFS. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes or the alphanumeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) not paid under the PFS in Addendum B.

Addendum B contains the following information for each CPT code and alphanumeric HCPCS code, except for: alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics); and codes for anesthesiology. Please also note the following:

- An ''NA'' in the ''Non-facility PE RVUs'' column of Addendum B means that CMS has not developed a PE RVU in the non-facility setting for the service because it is typically performed in the hospital (for example, an open heart surgery is generally performed in the hospital setting and not a physician's office). If there is an ''NA'' in the non-facility PE RVU column, and the contractor determines that this service can be performed in the non-facility setting, the service will be paid at the facility PE RVU rate.
- Services that have an ''NA'' in the ''Facility PE RVUs'' column of Addendum B are typically not paid using the PFS when provided in a facility setting. These services (which include ''incident to'' services and the technical portion of diagnostic tests) are generally paid under either the outpatient hospital prospective payment system or bundled into the hospital inpatient prospective payment system payment.

1. *CPT/HCPCS code*. This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. *Modifier*. A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier-26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code. A code for: the global values (both professional and technical); modifier-26 (PC); and, modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier-53 is shown for a discontinued procedure, for example a colonoscopy that is not completed. There will be RVUs for a code with this modifier.

3. *Status indicator*. This indicator shows whether the CPT/HCPCS code is in the PFS and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the PFS if covered. There will be RVUs for codes with this status. The presence of an ''A'' indicator does not mean that Medicare has made a national coverage determination regarding the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payments for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).

C = Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation, such as an operative report.

D * = Deleted/discontinued code.

E = Excluded from the PFS by regulation. These codes are for items and services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the PFS for these codes. Payment for them, when covered, continues under reasonable charge procedures.

F = Deleted/discontinued codes. (Code not subject to a 90-day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.

G = Code not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Codes subject to a 90-day grace period.) This indicator is no longer effective with the 2005 PFS as of January 1, 2005.

H * = Deleted modifier. For 2000 and later years, either the TC or PC component shown for the code has been deleted and the deleted component is shown in the database with the H status indicator.

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Codes not subject to a 90-day grace period.)

L = Local codes. Carriers will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. Carriers will complete the RVUs and payment amounts for these codes.

M = Measurement codes, used for reporting purposes only. There are no RVUs and no payment amounts for these codes. Medicare uses them to aid with performance measurement. No separate payment is made. These codes should be billed with a zero (($0.00) charge and are denied) on the MPFSDB.

N = Non-covered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = There are RVUs for these services, but they are only paid if there are no other services payable under the PFS billed on the same date by the same provider. If any other services payable under the PFS are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Statutory exclusion. These codes represent an item or service that is not within the statutory definition of ''physicians' services'' for PFS payment purposes. No RVUs are shown for these codes, and no payment may be made under the PFS. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. *Description of code*. This is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs*. These are the RVUs for the physician work for this service in 2010.

6. *Fully implemented non-facility PE RVUs*. These are the fully implemented resource-based practice PE RVUs for non-facility settings.

7. *2010 Transitional non-facility PE RVUs*. These are the 2010 resource-based PE RVUs for non-facility settings.

8. *Fully implemented facility PE RVUs*. These are the fully implemented resource-based practice PE RVUs for facility settings.

9. *2010 Transitional facility PE RVUs*. These are the 2010 resource-based PE RVUs for facility settings.

* Codes with these indicators had a 90-day grace period before January 1, 2005.

10. *Malpractice expense RVUs*. These are the RVUs for the malpractice expense for the service for 2010.

Note: The BN reduction resulting from the chiropractic demonstration is *not* reflected in the RVUs for CPT codes 98940, 98941 and 98942. The required reduction will only be reflected in the files used for Medicare payment.

9. *Global period*. This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = Code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = Code related to another service that is always included in the global period of the other service. (Note: Physician work and PE are associated with intra service time and in some instances in the post service time.

BILLING CODE 4120–01–P

ADDENDUM B: Relative Value Units and Related Information Used in Determining Medicare Payments for CY 2010

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
0016T		C	Thermotx choroid vasc lesion	0.00	0.00	0.00	0.00	0.00	0.00	0016T
0017T		C	Photocoagulat macular drusen	0.00	0.00	0.00	0.00	0.00	0.00	0017T
0019T		C	Extracorp shock wv tx,ms nos	0.00	0.00	0.00	0.00	0.00	0.00	0019T
0030T		C	Antiprothrombin antibody	0.00	0.00	0.00	0.00	0.00	0.00	0030T
0042T		C	Ct perfusion w/contrast, cbf	0.00	0.00	0.00	0.00	0.00	0.00	0042T
0048T		C	Implant ventricular device	0.00	0.00	0.00	0.00	0.00	0.00	0048T
0050T		C	Removal circulation assist	0.00	0.00	0.00	0.00	0.00	0.00	0050T
0051T		C	Implant total heart system	0.00	0.00	0.00	0.00	0.00	0.00	0051T
0052T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	0052T
0053T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	0053T
0054T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	0054T
0055T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	0055T
0071T		C	U/s leiomyomata ablate <200	0.00	0.00	0.00	0.00	0.00	0.00	0071T
0072T		C	U/s leiomyomata ablate >200	0.00	0.00	0.00	0.00	0.00	0.00	0072T
0073T		A	Delivery, comp imrt	0.00	12.00	13.88	NA	NA	0.01	0073T
0075T		C	Perq stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	0075T
0075T	TC	C	Perq stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	0075T
0075T	26	C	Perq stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	0075T
0076T		C	S&i stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	0076T
0076T	TC	C	S&i stent/chest vert art	0.00	0.00	0.00	NA	NA	0.00	0076T
0076T	26	C	S&i stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	0076T
0078T		C	Endovasc aort repr w/device	0.00	0.00	0.00	0.00	0.00	0.00	0078T
0079T		C	Endovasc visc extnsn repr	0.00	0.00	0.00	0.00	0.00	0.00	0079T
0080T		C	Endovasc aort repr rad s&i	0.00	0.00	0.00	0.00	0.00	0.00	0080T
0081T		C	Endovasc visc extnsn s&i	0.00	0.00	0.00	0.00	0.00	0.00	0081T
0085T		N	Breath test heart reject	0.00	0.00	0.00	0.00	0.00	0.00	0085T
0092T		C	Artific disc addl	0.00	0.00	0.00	0.00	0.00	0.00	0092T
0095T		C	Artific diskectomy addl	0.00	0.00	0.00	0.00	0.00	0.00	0095T
0098T		C	Rev artific disc addl	0.00	0.00	0.00	0.00	0.00	0.00	0098T
0099T		C	Implant corneal ring	0.00	0.00	0.00	0.00	0.00	0.00	0099T
0100T		C	Prosth retina receive&gen	0.00	0.00	0.00	0.00	0.00	0.00	0100T
0101T		C	Extracorp shockwv tx,hi enrg	0.00	0.00	0.00	0.00	0.00	0.00	0101T
0102T		C	Extracorp shockwv tx,anesth	0.00	0.00	0.00	0.00	0.00	0.00	0102T
0103T		C	Holotranscobalamin	0.00	0.00	0.00	0.00	0.00	0.00	0103T
0104T		C	At rest cardio gas rebreathe	0.00	0.00	0.00	0.00	0.00	0.00	0104T
0105T		C	Exerc cardio gas rebreathe	0.00	0.00	0.00	0.00	0.00	0.00	0105T

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[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes.
[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
0106T		C	Touch quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	0106T
0107T		C	Vibrate quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	0107T
0108T		C	Cool quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	0108T
0109T		C	Heat quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	0109T
0110T		C	Nos quant sensory test	0.00	0.00	0.00	0.00	0.00	0.00	0110T
0111T		C	Rbc membranes fatty acids	0.00	0.00	0.00	0.00	0.00	0.00	0111T
0123T		C	Scleral fistulization	0.00	0.00	0.00	0.00	0.00	0.00	0123T
0124T		C	Conjunctival drug placement	0.00	0.00	0.00	0.00	0.00	0.00	0124T
0126T		C	Chd risk imt study	0.00	0.00	0.00	0.00	0.00	0.00	0126T
0130T		C	Chron care drug investigatn	0.00	0.00	0.00	0.00	0.00	0.00	0130T
0140T		C	Exhaled breath condensate ph	0.00	0.00	0.00	0.00	0.00	0.00	0140T
0141T		I	Perq islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	0141T
0142T		I	Open islet transplant	0.00	0.00	0.00	0.00	0.00	0.00	0142T
0143T		I	Laparoscopic islet transplnt	0.00	0.00	0.00	0.00	0.00	0.00	0143T
0155T		C	Lap impl gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	0155T
0156T		C	Lap remv gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	0156T
0157T		C	Open impl gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	0157T
0158T		C	Open remv gast curve electrd	0.00	0.00	0.00	0.00	0.00	0.00	0158T
0159T		C	Cad breast mri	0.00	0.00	0.00	NA	NA	0.00	0159T
0159T	TC	C	Cad breast mri	0.00	0.00	0.00	NA	NA	0.00	0159T
0159T	26	C	Cad breast mri	0.00	0.00	0.00	0.00	0.00	0.00	0159T
0160T		C	Tcranial magn stim tx plan	0.00	0.00	0.00	0.00	0.00	0.00	0160T
0161T		C	Tcranial magn stim tx deliv	0.00	0.00	0.00	0.00	0.00	0.00	0161T
0163T		C	Lumb artif diskectomy addl	0.00	0.00	0.00	0.00	0.00	0.00	0163T
0164T		C	Remove lumb artif disc addl	0.00	0.00	0.00	0.00	0.00	0.00	0164T
0165T		C	Revise lumb artif disc addl	0.00	0.00	0.00	0.00	0.00	0.00	0165T
0166T		C	Tcath vsd close w/o bypass	0.00	0.00	0.00	0.00	0.00	0.00	0166T
0167T		C	Tcath vsd close w bypass	0.00	0.00	0.00	0.00	0.00	0.00	0167T
0168T		C	Rhinophototx light app bilat	0.00	0.00	0.00	0.00	0.00	0.00	0168T
0169T		C	Place stereo cath brain	0.00	0.00	0.00	0.00	0.00	0.00	0169T
0171T		C	Lumbar spine proces distract	0.00	0.00	0.00	0.00	0.00	0.00	0171T
0172T		C	Lumbar spine process addl	0.00	0.00	0.00	0.00	0.00	0.00	0172T
0173T		C	Iop monit io pressure	0.00	0.00	0.00	0.00	0.00	0.00	0173T
0174T		C	Cad cxr with interp	0.00	0.00	0.00	0.00	0.00	0.00	0174T
0175T		C	Cad cxr remote	0.00	0.00	0.00	0.00	0.00	0.00	0175T
0176T		C	Aqu canal dilat w/o retent	0.00	0.00	0.00	0.00	0.00	0.00	0176T
0177T		C	Aqu canal dilat w retent	0.00	0.00	0.00	0.00	0.00	0.00	0177T
0178T		C	64 lead ecg w i&r	0.00	0.00	0.00	0.00	0.00	0.00	0178T
0179T		C	64 lead ecg w tracing	0.00	0.00	0.00	0.00	0.00	0.00	0179T

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
0180T		C	64 lead ecg w i&r only	0.00	0.00	0.00	0.00	0.00	0.00	0180T
0181T		C	Corneal hysteresis	0.00	0.00	0.00	0.00	0.00	0.00	0181T
0182T		C	Hdr elect brachytherapy	0.00	0.00	0.00	NA	NA	0.00	0182T
0182T	TC	C	Hdr elect brachytherapy	0.00	0.00	0.00	0.00	0.00	0.00	0182T
0182T	26	C	Hdr elect brachytherapy	0.00	0.00	0.00	0.00	0.00	0.00	0182T
0183T		C	Wound ultrasound	0.00	0.00	0.00	0.00	0.00	0.00	0183T
0184T		C	Exc rectal tumor endoscopic	0.00	0.00	0.00	0.00	0.00	0.00	0184T
0185T		C	Comptr probability analysis	0.00	0.00	0.00	0.00	0.00	0.00	0185T
0186T		C	Suprachoroidal drug delivery	0.00	0.00	0.00	0.00	0.00	0.00	0186T
0187T		C	Ophthalmic dx image anterior	0.00	0.00	0.00	0.00	0.00	0.00	0187T
0188T		N	Videoconf crit care 74 min	0.00	0.00	0.00	0.00	0.00	0.00	0188T
0189T		N	Videoconf crit care addl 30	0.00	0.00	0.00	0.00	0.00	0.00	0189T
0190T		C	Place intraoc radiation src	0.00	0.00	0.00	0.00	0.00	0.00	0190T
0191T		C	Insert ant segment drain int	0.00	0.00	0.00	0.00	0.00	0.00	0191T
0192T		C	Insert ant segment drain ext	0.00	0.00	0.00	0.00	0.00	0.00	0192T
0193T		C	Rf bladder neck microremodel	0.00	0.00	0.00	0.00	0.00	0.00	0193T
0195T		C	Arthrod presac interbody	0.00	0.00	0.00	0.00	0.00	0.00	0195T
0196T		C	Arthrod presac interbody eac	0.00	0.00	0.00	0.00	0.00	0.00	0196T
0197T		C	Intrafraction track motion	0.00	0.00	0.00	0.00	0.00	0.00	0197T
0198T		C	Ocular blood flow measure	0.00	0.00	0.00	0.00	0.00	0.00	0198T
0199T		C	Physiologic tremor record	0.00	0.00	0.00	0.00	0.00	0.00	0199T
0200T		C	Perq sacral augmt unilat inj	0.00	0.00	0.00	0.00	0.00	0.00	0200T
0201T		C	Perq sacral augmt bilat inj	0.00	0.00	0.00	0.00	0.00	0.00	0201T
0202T		C	Post vert arthrplst 1 lumbar	0.00	0.00	0.00	0.00	0.00	0.00	0202T
0203T		C	Unattend sleep study w/time	0.00	0.00	0.00	0.00	0.00	0.00	0203T
0203T	TC	C	Unattend sleep study w/time	0.00	0.00	0.00	0.00	0.00	0.00	0203T
0203T	26	C	Unattend sleep study w/time	0.00	0.00	0.00	0.00	0.00	0.00	0203T
0204T		C	Unattended sleep study	0.00	0.00	0.00	0.00	0.00	0.00	0204T
0204T	TC	C	Unattended sleep study	0.00	0.00	0.00	0.00	0.00	0.00	0204T
0204T	26	C	Unattended sleep study	0.00	0.00	0.00	0.00	0.00	0.00	0204T
0205T		C	Inirs each vessel add-on	0.00	0.00	0.00	0.00	0.00	0.00	0205T
0206T		C	Remote algorithm analys ecg	0.00	0.00	0.00	0.00	0.00	0.00	0206T
0207T		C	Clear eyelid gland w/heat	0.00	0.00	0.00	0.00	0.00	0.00	0207T
0208T		C	Automated audiometry air	0.00	0.00	0.00	0.00	0.00	0.00	0208T
0209T		C	Auto audiometry air/bone	0.00	0.00	0.00	0.00	0.00	0.00	0209T
0210T		C	Auto audiometry sp thresh	0.00	0.00	0.00	0.00	0.00	0.00	0210T
0211T		C	Auto audiometry sp thresh	0.00	0.00	0.00	0.00	0.00	0.00	0211T
0212T		C	Comprehen auto audiometry	0.00	0.00	0.00	0.00	0.00	0.00	0212T
0213T		C	Us facet jt inj cerv/t 1 lev	0.00	0.00	0.00	0.00	0.00	0.00	0213T

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0214T		C	Us facet jt inj cerv/t 2 lev	0.00	0.00	0.00	0.00	0.00	0.00	0214T
0215T		C	Us facet jt inj cerv/t 3 lev	0.00	0.00	0.00	0.00	0.00	0.00	0215T
0216T		C	Us facet jt inj ls 1 level	0.00	0.00	0.00	0.00	0.00	0.00	0216T
0217T		C	Us facet jt inj ls 2 level	0.00	0.00	0.00	0.00	0.00	0.00	0217T
0218T		C	Us facet jt inj ls 3 level	0.00	0.00	0.00	0.00	0.00	0.00	0218T
0219T		C	Fuse spine facet jt cerv	0.00	0.00	0.00	0.00	0.00	0.00	0219T
0220T		C	Fuse spine facet jt thor	0.00	0.00	0.00	0.00	0.00	0.00	0220T
0221T		C	Fuse spine facet jt lumbar	0.00	0.00	0.00	0.00	0.00	0.00	0221T
0222T		C	Fuse spine facet jt add seg	0.00	0.00	0.00	0.00	0.00	0.00	0222T
0528F		I	Rcmnd flw-up 10 yrs docd	0.00	0.00	0.00	0.00	0.00	0.00	0528F
0535F		I	Dyspnea mngmnt plan docd	0.00	0.00	0.00	0.00	0.00	0.00	0535F
0545F		I	Follow up care plan mdd docd	0.00	0.00	0.00	0.00	0.00	0.00	0545F
0575F		I	HIV rna plan care docd	0.00	0.00	0.00	0.00	0.00	0.00	0575F
10021		A	Fna w/o image	1.27	2.31	2.23	0.52	0.46	0.15	10021
10022		A	Fna w/image	1.27	2.05	2.24	0.42	0.43	0.11	10022
10040		A	Acne surgery	1.21	1.36	1.31	1.05	0.99	0.12	10040
10060		A	Drainage of skin abscess	1.22	1.67	1.50	1.22	1.10	0.09	10060
10061		A	Drainage of skin abscess	2.45	2.30	2.10	1.69	1.57	0.22	10061
10080		A	Drainage of pilonidal cyst	1.22	3.04	2.86	1.32	1.17	0.14	10080
10081		A	Drainage of pilonidal cyst	2.50	4.13	3.82	1.83	1.59	0.33	10081
10120		A	Remove foreign body	1.25	2.25	2.08	1.13	1.01	0.12	10120
10121		A	Remove foreign body	2.74	3.99	3.65	1.94	1.77	0.29	10121
10140		A	Drainage of hematoma/fluid	1.58	2.46	2.23	1.41	1.34	0.14	10140
10160		A	Puncture drainage of lesion	1.25	2.01	1.85	1.19	1.12	0.12	10160
10180		A	Complex drainage, wound	2.30	3.69	3.35	2.11	1.95	0.34	10180
11000		A	Debride infected skin	0.60	0.77	0.71	0.17	0.18	0.04	11000
11001		A	Debride infected skin add-on	0.30	0.25	0.24	0.09	0.09	0.02	11001
11004		A	Debride genitalia & perineum	10.80	NA	NA	3.89	3.70	1.37	11004
11005		A	Debride abdom wall	14.24	NA	NA	5.31	4.73	2.15	11005
11006		A	Debride genit/per/abdom wall	13.10	NA	NA	4.80	4.53	1.72	11006
11008		A	Remove mesh from abd wall	5.00	NA	NA	1.87	1.66	0.75	11008
11010		A	Debride skin, fx	4.19	7.89	7.23	2.88	2.63	0.56	11010
11011		A	Debride skin/muscle, fx	4.94	8.08	7.66	2.61	2.35	0.70	11011
11012		A	Debride skin/muscle/bone, fx	6.87	10.49	10.15	3.87	3.61	0.95	11012
11040		A	Debride skin, partial	0.50	0.72	0.66	0.16	0.17	0.03	11040
11041		A	Debride skin, full	0.60	0.77	0.72	0.20	0.22	0.04	11041
11042		A	Debride skin/tissue	0.80	1.07	1.00	0.29	0.30	0.08	11042
11043		A	Debride tissue/muscle	3.14	4.07	3.66	3.07	2.75	0.36	11043
11044		A	Debride tissue/muscle/bone	4.26	5.68	5.06	4.27	3.87	0.52	11044

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
11055		R	Trim skin lesion	0.43	0.84	0.77	0.10	0.13	0.02	11055
11056		R	Trim skin lesions, 2 to 4	0.61	0.92	0.84	0.15	0.17	0.03	11056
11057		R	Trim skin lesions, over 4	0.79	1.02	0.95	0.19	0.22	0.04	11057
11100		A	Biopsy, skin lesion	0.81	1.74	1.75	0.47	0.43	0.08	11100
11101		A	Biopsy, skin add-on	0.41	0.42	0.41	0.24	0.22	0.04	11101
11200		A	Removal of skin tags	0.82	1.34	1.24	1.01	0.92	0.08	11200
11201		A	Remove skin tags add-on	0.29	0.20	0.17	0.15	0.13	0.03	11201
11300		A	Shave skin lesion	0.51	1.21	1.17	0.27	0.24	0.05	11300
11301		A	Shave skin lesion	0.85	1.47	1.44	0.48	0.43	0.09	11301
11302		A	Shave skin lesion	1.05	1.72	1.69	0.60	0.53	0.11	11302
11303		A	Shave skin lesion	1.24	2.01	1.97	0.69	0.61	0.13	11303
11305		A	Shave skin lesion	0.67	1.12	1.04	0.22	0.23	0.05	11305
11306		A	Shave skin lesion	0.99	1.43	1.37	0.43	0.41	0.08	11306
11307		A	Shave skin lesion	1.14	1.70	1.65	0.57	0.53	0.11	11307
11308		A	Shave skin lesion	1.41	1.76	1.69	0.55	0.55	0.11	11308
11310		A	Shave skin lesion	0.73	1.38	1.35	0.40	0.35	0.08	11310
11311		A	Shave skin lesion	1.05	1.61	1.58	0.60	0.54	0.11	11311
11312		A	Shave skin lesion	1.20	1.87	1.84	0.69	0.63	0.13	11312
11313		A	Shave skin lesion	1.62	2.20	2.16	0.91	0.81	0.17	11313
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.90	2.09	1.99	1.10	0.99	0.10	11400
11401		A	Exc tr-ext b9+marg 0.6-1 cm	1.28	2.35	2.24	1.32	1.20	0.14	11401
11402		A	Exc tr-ext b9+marg 1.1-2 cm	1.45	2.58	2.46	1.40	1.27	0.17	11402
11403		A	Exc tr-ext b9+marg 2.1-3 cm	1.84	2.83	2.64	1.83	1.62	0.22	11403
11404		A	Exc tr-ext b9+marg 3.1-4 cm	2.11	3.21	2.98	1.94	1.72	0.26	11404
11406		A	Exc tr-ext b9+marg > 4.0 cm	3.52	4.12	3.67	2.59	2.21	0.48	11406
11420		A	Exc h-f-nk-sp b9+marg 0.5 <	1.03	2.00	1.87	1.05	0.98	0.09	11420
11421		A	Exc h-f-nk-sp b9+marg 0.6-1	1.47	2.39	2.26	1.32	1.22	0.15	11421
11422		A	Exc h-f-nk-sp b9+marg 1.1-2	1.68	2.62	2.47	1.72	1.57	0.18	11422
11423		A	Exc h-f-nk-sp b9+marg 2.1-3	2.06	2.92	2.76	1.90	1.72	0.24	11423
11424		A	Exc h-f-nk-sp b9+marg 3.1-4	2.48	3.28	3.06	2.05	1.85	0.30	11424
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	4.09	4.12	3.79	2.79	2.47	0.51	11426
11440		A	Exc face-mm b9+marg 0.5 < cm	1.05	2.22	2.13	1.51	1.39	0.11	11440
11441		A	Exc face-mm b9+marg 0.6-1 cm	1.53	2.59	2.47	1.77	1.63	0.17	11441
11442		A	Exc face-mm b9+marg 1.1-2 cm	1.77	2.85	2.72	1.89	1.74	0.20	11442
11443		A	Exc face-mm b9+marg 2.1-3 cm	2.34	3.19	3.01	2.15	1.97	0.27	11443
11444		A	Exc face-mm b9+marg 3.1-4 cm	3.19	3.81	3.55	2.59	2.31	0.38	11444

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
			cm							
11446		A	Exc face-mm b9+marg > 4 cm	4.80	4.89	4.39	3.43	2.99	0.58	11446
11450		A	Removal, sweat gland lesion	3.22	5.96	5.40	2.98	2.54	0.46	11450
11451		A	Removal, sweat gland lesion	4.43	7.22	6.68	3.54	3.06	0.64	11451
11462		A	Removal, sweat gland lesion	3.00	6.08	5.53	3.00	2.56	0.42	11462
11463		A	Removal, sweat gland lesion	4.43	7.48	6.98	3.64	3.20	0.64	11463
11470		A	Removal, sweat gland lesion	3.74	6.32	5.69	3.26	2.79	0.51	11470
11471		A	Removal, sweat gland lesion	4.89	7.49	6.83	3.78	3.22	0.65	11471
1150F		I	Doc pt rsk death w/in 1yr	0.00	0.00	0.00	0.00	0.00	0.00	1150F
1151F		I	Doc no pt rsk death w/in 1yr	0.00	0.00	0.00	0.00	0.00	0.00	1151F
1152F		I	Doc advncd dis comfort 1st	0.00	0.00	0.00	0.00	0.00	0.00	1152F
1153F		I	Doc advncd dis cmfrt not 1st	0.00	0.00	0.00	0.00	0.00	0.00	1153F
1157F		I	Advnc care plan in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	1157F
1158F		I	Advnc care plan tlk docd	0.00	0.00	0.00	0.00	0.00	0.00	1158F
1159F		I	Med list docd in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	1159F
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.63	3.05	2.83	1.39	1.20	0.17	11600
11601		A	Exc tr-ext mlg+marg 0.6-1 cm	2.07	3.55	3.39	1.73	1.56	0.22	11601
11602		A	Exc tr-ext mlg+marg 1.1-2 cm	2.27	3.84	3.71	1.91	1.73	0.24	11602
11603		A	Exc tr-ext mlg+marg 2.1-3 cm	2.82	4.18	3.97	2.18	1.92	0.31	11603
11604		A	Exc tr-ext mlg+marg 3.1-4 cm	3.17	4.58	4.31	2.30	2.01	0.37	11604
11606		A	Exc tr-ext mlg+marg > 4 cm	5.02	6.09	5.49	3.09	2.59	0.64	11606
1160F		I	Rvw meds by rx/dr in rcrd	0.00	0.00	0.00	0.00	0.00	0.00	1160F
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.64	3.11	2.91	1.43	1.24	0.18	11620
11621		A	Exc h-f-nk-sp mlg+marg 0.6-1	2.08	3.59	3.43	1.76	1.59	0.22	11621
11622		A	Exc h-f-nk-sp mlg+marg 1.1-2	2.41	3.93	3.80	1.99	1.81	0.26	11622
11623		A	Exc h-f-nk-sp mlg+marg 2.1-3	3.11	4.35	4.12	2.33	2.06	0.35	11623
11624		A	Exc h-f-nk-sp mlg+marg 3.1-4	3.62	4.78	4.48	2.53	2.22	0.43	11624
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.61	5.54	5.15	2.92	2.59	0.57	11626
11640		A	Exc face-mm malig+marg 0.5 <	1.67	3.23	3.06	1.51	1.34	0.18	11640
11641		A	Exc face-mm malig+marg 0.6-1	2.17	3.70	3.59	1.84	1.71	0.23	11641
11642		A	Exc face-mm malig+marg 1.1-2	2.62	4.11	4.00	2.11	1.95	0.29	11642
11643		A	Exc face-mm malig+marg 2.1-3	3.42	4.55	4.34	2.51	2.26	0.39	11643
11644		A	Exc face-mm malig+marg 3.1-4	4.34	5.49	5.19	2.99	2.69	0.51	11644
11646		A	Exc face-mm mlg+marg > 4 cm	6.26	6.67	6.20	3.95	3.54	0.75	11646
11719		R	Trim nail(s)	0.17	0.39	0.36	0.04	0.05	0.01	11719
11720		A	Debride nail, 1-5	0.32	0.48	0.44	0.08	0.09	0.02	11720
11721		A	Debride nail, 6 or more	0.54	0.56	0.53	0.13	0.16	0.03	11721
11730		A	Removal of nail plate	1.10	1.39	1.29	0.27	0.31	0.06	11730
11732		A	Remove nail plate, add-on	0.57	0.57	0.53	0.14	0.17	0.03	11732

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
11740		A	Drain blood from under nail	0.37	0.84	0.76	0.45	0.42	0.02	11740
11750		A	Removal of nail bed	2.50	3.14	2.86	1.99	1.89	0.14	11750
11752		A	Remove nail bed/finger tip	3.63	4.45	3.99	3.05	2.93	0.28	11752
11755		A	Biopsy, nail unit	1.31	2.11	1.96	0.79	0.78	0.09	11755
11760		A	Repair of nail bed	1.63	4.00	3.44	1.71	1.59	0.18	11760
11762		A	Reconstruction of nail bed	2.94	4.14	3.67	1.88	1.89	0.22	11762
11765		A	Excision of nail fold, toe	0.74	2.84	2.54	1.07	0.97	0.04	11765
11770		A	Removal of pilonidal lesion	2.66	4.05	3.66	1.90	1.65	0.37	11770
11771		A	Removal of pilonidal lesion	6.09	7.93	6.93	4.66	3.99	0.88	11771
11772		A	Removal of pilonidal lesion	7.35	9.52	8.41	6.80	5.88	1.04	11772
1180F		I	Thromboemb risk assessed	0.00	0.00	0.00	0.00	0.00	0.00	1180F
11900		A	Injection into skin lesions	0.52	0.87	0.87	0.30	0.27	0.05	11900
11901		A	Added skin lesions injection	0.80	0.99	0.96	0.48	0.43	0.08	11901
11920		R	Correct skin color defects	1.61	2.62	2.72	1.32	1.19	0.22	11920
11921		R	Correct skin color defects	1.93	2.99	3.02	1.52	1.36	0.27	11921
11922		R	Correct skin color defects	0.49	1.03	0.99	0.28	0.25	0.07	11922
11950		R	Therapy for contour defects	0.84	1.05	1.01	0.54	0.44	0.08	11950
11951		R	Therapy for contour defects	1.19	1.45	1.30	0.74	0.58	0.17	11951
11952		R	Therapy for contour defects	1.69	1.43	1.66	0.67	0.77	0.17	11952
11954		R	Therapy for contour defects	1.85	2.18	2.06	1.13	0.96	0.26	11954
11960		A	Insert tissue expander(s)	11.49	NA	NA	11.65	11.09	1.27	11960
11970		A	Replace tissue expander	8.01	NA	NA	7.42	6.63	1.11	11970
11971		A	Remove tissue expander(s)	3.41	8.16	7.94	4.63	4.17	0.44	11971
11975		N	Insert contraceptive cap	1.48	1.81	1.76	0.54	0.53	0.07	11975
11976		R	Removal of contraceptive cap	1.78	1.80	1.82	0.68	0.59	0.22	11976
11977		N	Removal/reinsert contra cap	3.30	2.50	2.47	1.20	1.18	0.17	11977
11980		A	Implant hormone pellet(s)	1.48	1.16	1.10	0.62	0.55	0.16	11980
11981		A	Insert drug implant device	1.48	1.78	1.86	0.58	0.63	0.17	11981
11982		A	Remove drug implant device	1.78	1.80	2.01	0.68	0.77	0.18	11982
11983		A	Remove/insert drug implant	3.30	2.13	2.53	1.13	1.38	0.25	11983
12001		A	Repair superficial wound(s)	1.75	2.16	1.90	0.97	0.81	0.20	12001
12002		A	Repair superficial wound(s)	1.91	2.22	1.96	1.09	0.92	0.23	12002
12004		A	Repair superficial wound(s)	2.29	2.54	2.25	1.19	1.02	0.28	12004
12005		A	Repair superficial wound(s)	2.91	3.07	2.73	1.36	1.18	0.36	12005
12006		A	Repair superficial wound(s)	3.71	3.66	3.26	1.65	1.44	0.46	12006
12007		A	Repair superficial wound(s)	4.16	3.99	3.66	1.84	1.67	0.52	12007
1200F		I	Seizure type(s)+ frq docd	0.00	0.00	0.00	0.00	0.00	0.00	1200F
12011		A	Repair superficial wound(s)	1.81	2.31	2.06	0.96	0.82	0.22	12011
12013		A	Repair superficial wound(s)	2.04	2.49	2.22	1.11	0.96	0.25	12013

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
12014		A	Repair superficial wound(s)	2.51	2.77	2.48	1.22	1.07	0.30	12014
12015		A	Repair superficial wound(s)	3.24	3.34	3.01	1.40	1.23	0.40	12015
12016		A	Repair superficial wound(s)	3.97	3.83	3.46	1.61	1.45	0.49	12016
12017		A	Repair superficial wound(s)	4.75	NA	NA	1.51	1.59	0.60	12017
12018		A	Repair superficial wound(s)	5.57	NA	NA	1.64	2.12	0.70	12018
12020		A	Closure of split wound	2.67	4.15	3.86	2.07	1.90	0.31	12020
12021		A	Closure of split wound	1.89	2.11	1.94	1.56	1.43	0.22	12021
12031		A	Intmd wnd repair s/tr/ext	2.20	3.97	3.67	1.99	1.73	0.25	12031
12032		A	Intmd wnd repair s/tr/ext	2.52	5.03	4.98	2.44	2.30	0.28	12032
12034		A	Intmd wnd repair s/tr/ext	2.97	4.73	4.42	2.24	2.01	0.36	12034
12035		A	Intmd wnd repair s/tr/ext	3.47	5.84	5.48	2.50	2.28	0.46	12035
12036		A	Intmd wnd repair s/tr/ext	4.09	6.09	5.64	2.70	2.46	0.57	12036
12037		A	Intmd wnd repair s/tr/ext	4.71	6.65	6.21	3.14	2.90	0.66	12037
12041		A	Intmd wnd repair n-hf/genit	2.42	4.04	3.72	2.03	1.77	0.27	12041
12042		A	Intmd wnd repair n-hg/genit	2.79	4.45	4.32	2.33	2.12	0.30	12042
12044		A	Intmd wnd repair n-hg/genit	3.19	5.65	5.10	2.23	2.02	0.37	12044
12045		A	Intmd wnd repair n-hg/genit	3.68	5.66	5.32	2.50	2.28	0.45	12045
12046		A	Intmd wnd repair n-hg/genit	4.29	8.03	6.66	3.51	2.84	0.61	12046
12047		A	Intmd wnd repair n-hg/genit	4.69	8.24	6.98	3.98	3.15	0.66	12047
12051		A	Intmd wnd repair face/mm	2.52	4.18	4.02	2.15	1.95	0.28	12051
12052		A	Intmd wnd repair face/mm	2.87	4.79	4.61	2.75	2.47	0.31	12052
12053		A	Intmd wnd repair face/mm	3.17	5.38	5.04	2.36	2.14	0.36	12053
12054		A	Intmd wnd repair, face/mm	3.50	5.63	5.17	2.31	2.09	0.41	12054
12055		A	Intmd wnd repair face/mm	4.47	6.47	5.90	2.58	2.28	0.54	12055
12056		A	Intmd wnd repair face/mm	5.28	7.81	6.97	2.04	2.62	0.49	12056
12057		A	Intmd wnd repair face/mm	6.00	7.94	7.56	3.41	3.36	0.55	12057
1205F		I	EPI etiol synd rvwd and docd	0.00	0.00	0.00	0.00	0.00	0.00	1205F
13100		A	Repair of wound or lesion	3.17	4.57	4.52	2.77	2.62	0.36	13100
13101		A	Repair of wound or lesion	3.96	5.87	5.79	3.29	3.11	0.44	13101
13102		A	Repair wound/lesion add-on	1.24	1.45	1.37	0.67	0.60	0.16	13102
13120		A	Repair of wound or lesion	3.35	4.69	4.64	2.88	2.71	0.37	13120
13121		A	Repair of wound or lesion	4.42	6.59	6.45	3.94	3.68	0.47	13121
13122		A	Repair wound/lesion add-on	1.44	1.51	1.46	0.75	0.66	0.18	13122
13131		A	Repair of wound or lesion	3.83	5.07	5.00	3.19	3.02	0.41	13131
13132		A	Repair of wound or lesion	6.58	7.94	7.71	5.44	5.11	0.69	13132
13133		A	Repair wound/lesion add-on	2.19	2.04	1.94	1.23	1.11	0.25	13133
13150		A	Repair of wound or lesion	3.85	5.03	4.91	3.15	2.93	0.44	13150
13151		A	Repair of wound or lesion	4.49	5.62	5.52	3.61	3.43	0.48	13151
13152		A	Repair of wound or lesion	6.37	7.66	7.45	4.51	4.26	0.68	13152

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13153		A	Repair wound/lesion add-on	2.38	2.28	2.14	1.31	1.17	0.28	13153
13160		A	Late closure of wound	12.04	NA	NA	8.30	7.59	1.60	13160
14000		A	Skin tissue rearrangement	6.37	9.13	8.75	6.40	6.00	0.79	14000
14001		A	Skin tissue rearrangement	8.78	11.20	10.76	7.92	7.52	1.08	14001
14020		A	Skin tissue rearrangement	7.22	10.18	9.80	7.28	6.93	0.84	14020
14021		A	Skin tissue rearrangement	9.72	12.15	11.74	8.74	8.44	1.10	14021
14040		A	Skin tissue rearrangement	8.60	10.67	10.28	7.77	7.45	0.93	14040
14041		A	Skin tissue rearrangement	10.83	13.00	12.64	9.31	8.98	1.15	14041
14060		A	Skin tissue rearrangement	9.23	10.42	9.94	8.14	7.71	1.01	14060
14061		A	Skin tissue rearrangement	11.48	14.10	13.70	10.02	9.69	1.23	14061
14301		A	Skin tissue rearrangement	12.65	14.34	14.34	9.96	9.96	1.53	14301
14302		A	Skin tissue rearrange add-on	3.73	2.08	2.08	2.08	2.08	0.45	14302
14350		A	Skin tissue rearrangement	11.05	NA	NA	7.72	7.25	1.10	14350
15002		A	Wound prep, trk/arm/leg	3.65	4.88	4.43	2.14	1.86	0.48	15002
15003		A	Wound prep, addl 100 cm	0.80	1.05	0.95	0.36	0.31	0.11	15003
15004		A	Wound prep, f/n/hf/g	4.58	5.46	5.12	2.48	2.26	0.49	15004
15005		A	Wnd prep, f/n/hf/g, addl cm	1.60	1.49	1.32	0.73	0.60	0.23	15005
15040		A	Harvest cultured skin graft	2.00	4.35	4.19	1.30	1.13	0.27	15040
15050		A	Skin pinch graft	5.57	8.61	7.83	5.81	5.33	0.63	15050
15100		A	Skin splt grft, trnk/arm/leg	9.90	11.40	10.91	8.13	7.46	1.39	15100
15101		A	Skin splt grft t/a/l, add-on	1.72	2.81	2.83	1.07	1.00	0.25	15101
15110		A	Epidrm autogrft trnk/arm/leg	10.97	10.32	9.53	7.76	6.86	1.55	15110
15111		A	Epidrm autogrft t/a/l add-on	1.85	1.05	1.04	0.78	0.73	0.28	15111
15115		A	Epidrm a-grft face/nck/hf/g	11.28	10.46	9.60	7.95	7.25	1.32	15115
15116		A	Epidrm a-grft f/n/hf/g addl	2.50	1.82	1.53	1.46	1.16	0.35	15116
15120		A	Skn splt a-grft fac/nck/hf/g	11.16	12.94	11.82	9.00	8.10	1.37	15120
15121		A	Skn splt a-grft f/n/hf/g add	2.67	3.91	3.78	1.65	1.50	0.37	15121
15130		A	Derm autograft, trnk/arm/leg	7.53	9.10	8.69	6.57	6.06	1.05	15130
15131		A	Derm autograft t/a/l add-on	1.50	0.75	0.82	0.55	0.59	0.23	15131
15135		A	Derm autograft face/nck/hf/g	11.03	10.93	9.95	8.44	7.67	1.35	15135
15136		A	Derm autograft, f/n/hf/g add	1.50	0.72	0.67	0.59	0.52	0.08	15136
15150		A	Cult epiderm grft t/arm/leg	9.39	7.66	7.35	6.24	5.94	1.44	15150
15151		A	Cult epiderm grft t/a/l addl	2.00	0.96	1.01	0.74	0.77	0.31	15151
15152		A	Cult epiderm graft t/a/l +%	2.50	1.16	1.38	0.93	1.11	0.36	15152
15155		A	Cult epiderm graft, f/n/hf/g	10.14	5.74	7.03	4.60	5.86	0.55	15155
15156		A	Cult epidrm grft f/n/hfg add	2.75	1.46	1.48	1.26	1.25	0.42	15156
15157		A	Cult epiderm grft f/n/hfg +%	3.00	1.35	1.59	1.10	1.28	0.15	15157
15170		A	Acell graft trunk/arms/legs	5.99	5.03	4.41	3.48	2.95	0.78	15170
15171		A	Acell graft t/arm/leg add-on	1.55	0.80	0.72	0.65	0.59	0.23	15171

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15175		A	Acellular graft, f/n/hf/g	7.99	5.22	4.96	3.78	3.59	0.75	15175
15176		A	Acell graft, f/n/hf/g add-on	2.45	1.27	1.17	1.00	0.94	0.29	15176
15200		A	Skin full graft, trunk	9.15	11.50	10.53	7.87	7.00	1.17	15200
15201		A	Skin full graft trunk add-on	1.32	2.30	2.25	0.63	0.60	0.18	15201
15220		A	Skin full graft sclp/arm/leg	8.09	11.14	10.58	7.59	7.11	0.98	15220
15221		A	Skin full graft add-on	1.19	2.19	2.14	0.66	0.59	0.16	15221
15240		A	Skin full grft face/genit/hf	10.41	13.03	12.19	10.08	9.27	1.20	15240
15241		A	Skin full graft add-on	1.86	2.76	2.61	1.04	0.93	0.24	15241
15260		A	Skin full graft een & lips	11.64	13.81	13.00	10.51	9.80	1.24	15260
15261		A	Skin full graft add-on	2.23	3.18	3.01	1.44	1.33	0.27	15261
15300		A	Apply skinallogrft, t/arm/lg	4.65	4.22	3.69	2.78	2.41	0.62	15300
15301		A	Apply sknallogrft t/a/l addl	1.00	0.60	0.53	0.45	0.40	0.14	15301
15320		A	Apply skin allogrft f/n/hf/g	5.36	4.24	3.92	2.69	2.53	0.54	15320
15321		A	Aply sknallogrft f/n/hfg add	1.50	0.86	0.77	0.67	0.60	0.22	15321
15330		A	Aply acell alogrft t/arm/leg	3.99	4.19	3.70	2.72	2.40	0.56	15330
15331		A	Aply acell grft t/a/l add-on	1.00	0.60	0.53	0.46	0.41	0.14	15331
15335		A	Apply acell graft, f/n/hf/g	4.50	3.63	3.46	2.25	2.20	0.37	15335
15336		A	Aply acell grft f/n/hf/g add	1.43	0.55	0.63	0.35	0.44	0.08	15336
15340		A	Apply cult skin substitute	3.82	4.19	3.92	3.03	2.81	0.37	15340
15341		A	Apply cult skin sub add-on	0.50	0.71	0.65	0.16	0.16	0.05	15341
15360		A	Apply cult derm sub, t/a/l	4.02	5.00	4.79	3.67	3.48	0.42	15360
15361		A	Aply cult derm sub t/a/l add	1.15	0.63	0.57	0.44	0.39	0.14	15361
15365		A	Apply cult derm sub f/n/hf/g	4.30	4.42	4.30	3.23	3.12	0.29	15365
15366		A	Apply cult derm f/hf/g add	1.45	0.62	0.63	0.43	0.45	0.11	15366
15400		A	Apply skin xenograft, t/a/l	4.47	5.94	5.29	4.60	4.23	0.49	15400
15401		A	Apply skn xenogrft t/a/l add	1.00	1.14	1.22	0.42	0.38	0.15	15401
15420		A	Apply skin xgraft, f/n/hf/g	4.98	6.16	5.87	4.89	4.62	0.47	15420
15421		A	Apply skn xgrft f/n/hf/g add	1.50	1.39	1.27	0.67	0.57	0.22	15421
15430		A	Apply acellular xenograft	6.20	7.62	6.85	7.01	6.35	0.72	15430
15431		C	Apply acellular xgraft add	0.00	0.00	0.00	0.00	0.00	0.00	15431
15570		A	Form skin pedicle flap	10.21	11.99	11.17	7.97	7.18	1.47	15570
15572		A	Form skin pedicle flap	10.12	11.75	10.73	8.62	7.64	1.29	15572
15574		A	Form skin pedicle flap	10.70	12.30	11.31	8.95	8.05	1.29	15574
*15576		A	Form skin pedicle flap	9.37	11.00	10.25	7.94	7.18	1.09	15576
15600		A	Skin graft	2.01	5.82	5.93	3.13	2.95	0.27	15600
15610		A	Skin graft	2.52	6.13	5.60	3.51	3.30	0.33	15610
15620		A	Skin graft	3.75	7.08	6.95	4.48	4.11	0.43	15620
15630		A	Skin graft	4.08	7.35	7.23	4.75	4.49	0.46	15630
15650		A	Transfer skin pedicle flap	4.77	7.72	7.74	4.93	4.78	0.56	15650

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15731		A	Forehead flap w/vasc pedicle	14.38	14.52	13.44	11.84	10.77	1.73	15731
15732		A	Muscle-skin graft, head/neck	19.90	18.22	16.60	14.54	12.59	2.54	15732
15734		A	Muscle-skin graft, trunk	19.86	18.33	17.16	14.24	12.90	2.85	15734
15736		A	Muscle-skin graft, arm	17.04	16.17	15.47	12.16	11.02	2.41	15736
15738		A	Muscle-skin graft, leg	19.04	16.34	15.59	12.57	11.47	2.74	15738
15740		A	Island pedicle flap graft	11.80	13.99	13.36	10.39	9.78	1.25	15740
15750		A	Neurovascular pedicle graft	12.96	NA	NA	10.45	9.47	1.64	15750
15756		A	Free myo/skin flap microvasc	36.94	NA	NA	23.78	21.04	4.59	15756
15757		A	Free skin flap, microvasc	37.15	NA	NA	23.28	20.67	4.27	15757
15758		A	Free fascial flap, microvasc	36.90	NA	NA	22.99	20.64	4.28	15758
15760		A	Composite skin graft	9.86	11.72	10.89	8.42	7.66	1.12	15760
15770		A	Derma-fat-fascia graft	8.96	NA	NA	8.12	7.23	1.15	15770
15775		R	Hair transplant punch grafts	3.95	3.53	3.70	1.78	1.67	0.20	15775
15776		R	Hair transplant punch grafts	5.53	4.84	5.07	2.36	2.43	0.28	15776
15780		A	Abrasion treatment of skin	8.73	11.79	11.67	7.12	7.18	0.84	15780
15781		A	Abrasion treatment of skin	5.02	8.54	8.20	5.83	5.61	0.55	15781
15782		A	Abrasion treatment of skin	4.44	10.41	9.68	6.46	5.87	0.44	15782
15783		A	Abrasion treatment of skin	4.41	7.65	7.56	5.14	4.83	0.44	15783
15786		A	Abrasion, lesion, single	2.08	4.12	3.87	1.52	1.38	0.24	15786
15787		A	Abrasion, lesions, add-on	0.33	0.92	0.88	0.16	0.13	0.03	15787
15788		R	Chemical peel, face, epiderm	2.09	9.25	8.62	4.18	3.85	0.26	15788
15789		R	Chemical peel, face, dermal	4.91	8.62	8.91	5.62	5.60	0.50	15789
15792		R	Chemical peel, nonfacial	1.86	8.81	8.55	4.66	4.58	0.22	15792
15793		A	Chemical peel, nonfacial	3.96	8.10	7.84	5.22	4.97	0.39	15793
15819		A	Plastic surgery, neck	10.65	NA	NA	8.10	7.48	1.49	15819
15820		A	Revision of lower eyelid	6.27	8.02	7.12	6.77	5.86	0.86	15820
15821		A	Revision of lower eyelid	6.84	8.53	7.42	7.12	6.03	0.95	15821
15822		A	Revision of upper eyelid	4.62	6.54	5.82	5.31	4.61	0.57	15822
15823		A	Revision of upper eyelid	8.32	9.68	8.30	8.30	6.97	1.09	15823
15824		R	Removal of forehead wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	15824
15825		R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	15825
15826		R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	15826
15828		R	Removal of face wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	15828
15829		R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	15829
15830		R	Exc skin abd	17.11	NA	NA	12.50	10.90	2.42	15830
15832		A	Excise excessive skin tissue	12.85	NA	NA	9.85	8.81	1.84	15832
15833		A	Excise excessive skin tissue	11.90	NA	NA	10.34	8.80	1.68	15833
15834		A	Excise excessive skin tissue	12.17	NA	NA	10.50	8.49	1.72	15834
15835		A	Excise excessive skin tissue	12.99	NA	NA	10.96	8.89	1.84	15835

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15836		A	Excise excessive skin tissue	10.61	NA	NA	7.28	7.13	1.49	15836
15837		A	Excise excessive skin tissue	9.55	10.20	9.26	6.81	6.57	1.45	15837
15838		A	Excise excessive skin tissue	8.25	NA	NA	6.79	6.13	0.75	15838
15839		A	Excise excessive skin tissue	10.50	11.47	10.36	8.09	7.20	1.37	15839
15840		A	Graft for face nerve palsy	14.99	NA	NA	11.54	10.12	1.73	15840
15841		A	Graft for face nerve palsy	25.99	NA	NA	16.60	15.30	2.40	15841
15842		A	Flap for face nerve palsy	41.01	NA	NA	20.12	22.07	3.78	15842
15845		A	Skin and muscle repair, face	14.32	NA	NA	11.93	9.84	1.30	15845
15847		C	Exc skin abd add-on	0.00	0.00	0.00	0.00	0.00	0.00	15847
15850		B	Removal of sutures	0.78	1.37	1.44	0.28	0.28	0.04	15850
15851		A	Removal of sutures	0.86	1.54	1.45	0.34	0.29	0.09	15851
15852		A	Dressing change not for burn	0.86	NA	NA	0.33	0.31	0.11	15852
15860		A	Test for blood flow in graft	1.95	NA	NA	1.15	0.84	0.28	15860
15876		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	15876
15877		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	15877
15878		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	15878
15879		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	15879
15920		A	Removal of tail bone ulcer	8.29	NA	NA	6.79	6.00	1.22	15920
15922		A	Removal of tail bone ulcer	10.38	NA	NA	7.33	7.35	1.46	15922
15931		A	Remove sacrum pressure sore	10.07	NA	NA	6.88	6.06	1.49	15931
15933		A	Remove sacrum pressure sore	11.77	NA	NA	9.35	8.21	1.74	15933
15934		A	Remove sacrum pressure sore	13.68	NA	NA	9.61	8.42	2.01	15934
15935		A	Remove sacrum pressure sore	15.78	NA	NA	12.06	10.61	2.28	15935
15936		A	Remove sacrum pressure sore	13.16	NA	NA	9.23	8.19	1.93	15936
15937		A	Remove sacrum pressure sore	15.14	NA	NA	10.97	9.82	2.20	15937
15940		A	Remove hip pressure sore	10.20	NA	NA	7.16	6.34	1.50	15940
15941		A	Remove hip pressure sore	12.41	NA	NA	10.41	9.24	1.79	15941
15944		A	Remove hip pressure sore	12.44	NA	NA	9.98	8.86	1.80	15944
15945		A	Remove hip pressure sore	13.75	NA	NA	11.21	9.91	1.96	15945
15946		A	Remove hip pressure sore	24.12	NA	NA	17.30	15.30	3.44	15946
15950		A	Remove thigh pressure sore	8.03	NA	NA	6.34	5.75	1.14	15950
15951		A	Remove thigh pressure sore	11.58	NA	NA	8.35	7.91	1.63	15951
15952		A	Remove thigh pressure sore	12.31	NA	NA	8.14	8.03	1.89	15952
15953		A	Remove thigh pressure sore	13.57	NA	NA	11.80	9.72	1.92	15953
15956		A	Remove thigh pressure sore	16.79	NA	NA	12.01	10.75	2.44	15956
15958		A	Remove thigh pressure sore	16.75	NA	NA	12.70	11.39	2.42	15958
15999		C	Removal of pressure sore	0.00	0.00	0.00	0.00	0.00	0.00	15999
16000		A	Initial treatment of burn(s)	0.89	0.89	0.80	0.33	0.27	0.10	16000
16020		A	Dress/debrid p-thick burn, s	0.80	1.33	1.21	0.70	0.60	0.09	16020

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16025		A	Dress/debrid p-thick burn, m	1.85	1.97	1.74	1.15	0.99	0.22	16025
16030		A	Dress/debrid p-thick burn, l	2.08	2.48	2.22	1.32	1.13	0.27	16030
16035		A	Incision of burn scab, initi	3.74	NA	NA	1.35	1.38	0.45	16035
16036		A	Escharotomy; addl incision	1.50	NA	NA	0.63	0.56	0.19	16036
17000		A	Destruct premalg lesion	0.65	1.36	1.33	0.77	0.73	0.06	17000
17003		A	Destruct premalg les, 2-14	0.07	0.10	0.11	0.04	0.04	0.01	17003
17004		A	Destroy premlg lesions 15+	1.85	2.41	2.46	1.51	1.51	0.19	17004
17106		A	Destruction of skin lesions	3.69	4.82	4.76	3.28	3.20	0.38	17106
17107		A	Destruction of skin lesions	4.79	6.00	6.20	3.98	4.14	0.53	17107
17108		A	Destruction of skin lesions	7.49	8.17	7.88	5.49	5.41	0.81	17108
17110		A	Destruct b9 lesion, 1-14	0.70	2.01	2.02	1.06	1.01	0.06	17110
17111		A	Destruct lesion, 15 or more	0.97	2.27	2.26	1.21	1.15	0.09	17111
17250		A	Chemical cautery, tissue	0.50	1.43	1.34	0.43	0.39	0.05	17250
17260		A	Destruction of skin lesions	0.96	1.39	1.40	0.79	0.74	0.10	17260
17261		A	Destruction of skin lesions	1.22	2.31	2.30	1.13	1.07	0.12	17261
17262		A	Destruction of skin lesions	1.63	2.67	2.65	1.38	1.30	0.16	17262
17263		A	Destruction of skin lesions	1.84	2.90	2.88	1.50	1.39	0.18	17263
17264		A	Destruction of skin lesions	1.99	3.10	3.06	1.57	1.46	0.20	17264
17266		A	Destruction of skin lesions	2.39	3.40	3.34	1.79	1.63	0.25	17266
17270		A	Destruction of skin lesions	1.37	2.34	2.30	1.19	1.11	0.14	17270
17271		A	Destruction of skin lesions	1.54	2.52	2.49	1.32	1.24	0.15	17271
17272		A	Destruction of skin lesions	1.82	2.82	2.79	1.49	1.40	0.18	17272
17273		A	Destruction of skin lesions	2.10	3.07	3.04	1.65	1.53	0.21	17273
17274		A	Destruction of skin lesions	2.64	3.50	3.44	1.95	1.81	0.27	17274
17276		A	Destruction of skin lesions	3.25	3.90	3.77	2.28	2.07	0.34	17276
17280		A	Destruction of skin lesions	1.22	2.24	2.22	1.11	1.04	0.12	17280
17281		A	Destruction of skin lesions	1.77	2.62	2.60	1.45	1.36	0.18	17281
17282		A	Destruction of skin lesions	2.09	3.01	2.97	1.64	1.54	0.21	17282
17283		A	Destruction of skin lesions	2.69	3.48	3.41	1.99	1.84	0.27	17283
17284		A	Destruction of skin lesions	3.26	3.93	3.83	2.31	2.13	0.33	17284
17286		A	Destruction of skin lesions	4.48	4.67	4.45	2.96	2.72	0.48	17286
17311		A	Mohs, 1 stage, h/n/hf/g	6.20	10.00	10.66	3.72	3.43	0.63	17311
17312		A	Mohs addl stage	3.30	6.30	6.79	1.98	1.82	0.34	17312
17313		A	Mohs, 1 stage, t/a/l	5.56	9.20	9.83	3.34	3.08	0.57	17313
17314		A	Mohs, addl stage, t/a/l	3.06	5.84	6.30	1.83	1.69	0.31	17314
17315		A	Mohs surg, addl block	0.87	1.11	1.15	0.52	0.48	0.09	17315
17340		A	Cryotherapy of skin	0.77	0.54	0.45	0.48	0.40	0.08	17340
17360		A	Skin peel therapy	1.46	1.81	1.80	1.12	1.05	0.15	17360
17380		R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	0.00	0.00	17380

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17999		C	Skin tissue procedure	0.00	0.00	0.00	0.00	0.00	0.00	17999
19000		A	Drainage of breast lesion	0.84	1.82	1.93	0.27	0.30	0.08	19000
19001		A	Drain breast lesion add-on	0.42	0.25	0.26	0.13	0.15	0.04	19001
19020		A	Incision of breast lesion	3.83	7.54	6.88	3.65	3.19	0.55	19020
19030		A	Injection for breast x-ray	1.53	2.36	2.69	0.46	0.55	0.11	19030
19100		A	Bx breast percut w/o image	1.27	2.36	2.18	0.47	0.40	0.19	19100
19101		A	Biopsy of breast, open	3.23	5.04	4.63	2.22	1.97	0.48	19101
19102		A	Bx breast percut w/image	2.00	3.13	3.53	0.62	0.71	0.15	19102
19103		A	Bx breast percut w/device	3.69	9.43	10.34	1.18	1.28	0.34	19103
19105		A	Cryosurg ablate fa, each	3.69	43.39	50.09	1.30	1.32	0.29	19105
19110		A	Nipple exploration	4.44	7.47	6.63	4.00	3.43	0.66	19110
19112		A	Excise breast duct fistula	3.81	7.41	6.60	3.87	3.32	0.57	19112
19120		A	Removal of breast lesion	5.92	6.12	5.35	4.24	3.63	0.89	19120
19125		A	Excision, breast lesion	6.69	6.71	5.81	4.62	3.93	1.01	19125
19126		A	Excision, addl breast lesion	2.93	NA	NA	1.08	0.92	0.45	19126
19260		A	Removal of chest wall lesion	17.78	NA	NA	12.08	11.14	2.84	19260
19271		A	Revision of chest wall	22.19	NA	NA	18.32	17.35	3.60	19271
19272		A	Extensive chest wall surgery	25.17	NA	NA	19.11	18.41	4.26	19272
19290		A	Place needle wire, breast	1.27	2.57	2.86	0.38	0.46	0.09	19290
19291		A	Place needle wire, breast	0.63	1.02	1.14	0.19	0.22	0.05	19291
19295		A	Place breast clip, percut	0.00	2.08	2.32	NA	NA	0.01	19295
19296		A	Place po breast cath for rad	3.63	93.13	95.73	1.61	1.42	0.54	19296
19297		A	Place breast cath for rad	1.72	NA	NA	0.64	0.55	0.26	19297
19298		A	Place breast rad tube/caths	6.00	22.36	26.35	2.59	2.39	0.56	19298
19300		A	Removal of breast tissue	5.31	7.35	6.76	4.74	4.07	0.79	19300
19301		A	Partical mastectomy	10.13	NA	NA	6.00	4.90	1.54	19301
19302		A	P-mastectomy w/ln removal	13.99	NA	NA	8.05	6.89	2.14	19302
19303		A	Mast, simple, complete	15.85	NA	NA	9.15	7.41	2.42	19303
19304		A	Mast, subq	7.95	NA	NA	6.14	5.32	1.19	19304
19305		A	Mast, radical	17.46	NA	NA	10.50	8.93	2.66	19305
19306		A	Mast, rad, urban type	18.13	NA	NA	11.47	9.61	2.76	19306
19307		A	Mast, mod rad	18.23	NA	NA	11.34	9.60	2.76	19307
19316		A	Suspension of breast	11.09	NA	NA	8.39	7.57	1.58	19316
19318		A	Reduction of large breast	16.03	NA	NA	12.19	11.04	2.27	19318
19324		A	Enlarge breast	6.80	NA	NA	5.26	4.78	1.02	19324
19325		A	Enlarge breast with implant	8.64	NA	NA	7.73	6.94	1.20	19325
19328		A	Removal of breast implant	6.48	NA	NA	6.03	5.39	0.90	19328
19330		A	Removal of implant material	8.54	NA	NA	7.47	6.64	1.18	19330
19340		A	Immediate breast prosthesis	13.78	NA	NA	11.45	5.19	0.89	19340

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19342		A	Delayed breast prosthesis	12.63	NA	NA	10.91	9.70	1.76	19342
19350		A	Breast reconstruction	9.11	11.44	11.19	7.97	7.22	1.27	19350
19355		A	Correct inverted nipple(s)	8.52	8.66	8.50	5.55	5.10	1.29	19355
19357		A	Breast reconstruction	21.07	NA	NA	18.75	16.69	2.92	19357
19361		A	Breast reconstr w/lat flap	23.36	NA	NA	20.24	17.24	3.31	19361
19364		A	Breast reconstruction	42.58	NA	NA	28.17	24.97	5.95	19364
19366		A	Breast reconstruction	21.84	NA	NA	12.98	11.40	3.22	19366
19367		A	Breast reconstruction	26.80	NA	NA	18.93	16.98	3.77	19367
19368		A	Breast reconstruction	33.90	NA	NA	22.95	20.14	4.80	19368
19369		A	Breast reconstruction	31.31	NA	NA	21.43	18.46	4.43	19369
19370		A	Surgery of breast capsule	9.17	NA	NA	8.24	7.36	1.26	19370
19371		A	Removal of breast capsule	10.62	NA	NA	9.32	8.33	1.48	19371
19380		A	Revise breast reconstruction	10.41	NA	NA	9.20	8.23	1.45	19380
19396		A	Design custom breast implant	2.17	4.63	3.48	1.12	1.03	0.33	19396
19499		C	Breast surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	19499
20000		A	Incision of abscess	2.17	3.00	2.84	1.68	1.63	0.19	20000
20005		A	Incision of deep abscess	3.58	4.16	3.82	2.36	2.20	0.42	20005
20100		A	Explore wound, neck	10.38	NA	NA	4.84	4.04	1.43	20100
20101		A	Explore wound, chest	3.23	6.45	6.33	1.69	1.62	0.50	20101
20102		A	Explore wound, abdomen	3.98	7.91	7.37	2.37	2.06	0.57	20102
20103		A	Explore wound, extremity	5.34	9.01	8.36	3.47	3.18	0.70	20103
20150		A	Excise epiphyseal bar	14.75	NA	NA	8.29	8.30	2.09	20150
20200		A	Muscle biopsy	1.46	3.42	3.22	0.85	0.77	0.23	20200
20205		A	Deep muscle biopsy	2.35	4.48	4.06	1.41	1.24	0.41	20205
20206		A	Needle biopsy, muscle	0.99	4.79	5.43	0.52	0.60	0.08	20206
20220		A	Bone biopsy, trocar/needle	1.27	2.47	3.05	0.62	0.71	0.09	20220
20225		A	Bone biopsy, trocar/needle	1.87	11.30	14.37	0.95	1.08	0.17	20225
20240		A	Bone biopsy, excisional	3.28	NA	NA	2.40	2.28	0.38	20240
20245		A	Bone biopsy, excisional	8.95	NA	NA	6.86	6.33	1.17	20245
20250		A	Open bone biopsy	5.19	NA	NA	4.11	3.77	0.88	20250
20251		A	Open bone biopsy	5.72	NA	NA	4.44	4.17	0.95	20251
20500		A	Injection of sinus tract	1.28	1.35	1.55	0.89	1.03	0.09	20500
20501		A	Inject sinus tract for x-ray	0.76	2.12	2.45	0.23	0.28	0.05	20501
2050F		I	Wound char size etc docd	0.00	0.00	0.00	0.00	0.00	0.00	2050F
20520		A	Removal of foreign body	1.90	3.07	2.81	1.76	1.62	0.22	20520
20525		A	Removal of foreign body	3.54	8.16	7.85	2.70	2.48	0.46	20525
20526		A	Ther injection, carp tunnel	0.94	0.94	0.89	0.51	0.47	0.11	20526
20550		A	Inj tendon sheath/ligament	0.75	0.71	0.68	0.33	0.29	0.06	20550
20551		A	Inj tendon origin/insertion	0.75	0.78	0.69	0.38	0.33	0.06	20551

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20552		A	Inj trigger point, 1/2 muscl	0.66	0.71	0.65	0.33	0.27	0.05	20552
20553		A	Inject trigger points, =/> 3	0.75	0.83	0.74	0.37	0.29	0.06	20553
20555		A	Place ndl musc/tis for rt	6.00	NA	NA	2.60	2.44	0.62	20555
20600		A	Drain/inject, joint/bursa	0.66	0.72	0.69	0.35	0.33	0.05	20600
20605		A	Drain/inject, joint/bursa	0.68	0.82	0.77	0.38	0.35	0.06	20605
2060F		I	Pt talk eval hlthwkr re mdd	0.00	0.00	0.00	0.00	0.00	0.00	2060F
20610		A	Drain/inject, joint/bursa	0.79	1.20	1.10	0.49	0.44	0.09	20610
20612		A	Aspirate/inj ganglion cyst	0.70	0.81	0.74	0.38	0.36	0.07	20612
20615		A	Treatment of bone cyst	2.33	3.04	3.01	1.66	1.61	0.20	20615
20650		A	Insert and remove bone pin	2.28	2.73	2.54	1.60	1.54	0.21	20650
20660		A	Apply, rem fixation device	4.00	NA	NA	1.84	1.69	0.79	20660
20661		A	Application of head brace	5.26	NA	NA	6.58	5.98	1.17	20661
20662		A	Application of pelvis brace	6.38	NA	NA	4.00	5.07	0.44	20662
20663		A	Application of thigh brace	5.74	NA	NA	5.81	5.14	0.80	20663
20664		A	Halo brace application	10.06	NA	NA	10.07	8.56	2.57	20664
20665		A	Removal of fixation device	1.36	1.42	1.56	1.07	1.09	0.09	20665
20670		A	Removal of support implant	1.79	7.48	7.80	1.93	1.85	0.21	20670
20680		A	Removal of support implant	5.96	9.37	8.69	4.78	4.30	0.75	20680
20690		A	Apply bone fixation device	8.78	NA	NA	6.01	4.96	1.15	20690
20692		A	Apply bone fixation device	16.27	NA	NA	11.94	9.62	2.00	20692
20693		A	Adjust bone fixation device	6.06	NA	NA	5.35	5.04	0.76	20693
20694		A	Remove bone fixation device	4.28	6.21	5.99	4.18	3.88	0.55	20694
20696		A	Comp multiplane ext fixation	17.56	NA	NA	9.96	8.60	0.87	20696
20697		A	Comp ext fixate strut change	0.00	38.72	35.07	NA	NA	0.01	20697
20802		A	Replantation, arm, complete	42.62	NA	NA	19.27	18.01	2.14	20802
20805		A	Replant forearm, complete	51.46	NA	NA	30.88	24.37	7.31	20805
20808		A	Replantation hand, complete	63.09	NA	NA	42.00	37.99	8.97	20808
20816		A	Replantation digit, complete	31.95	NA	NA	19.81	22.11	2.87	20816
20822		A	Replantation digit, complete	26.66	NA	NA	17.70	19.19	3.77	20822
20824		A	Replantation thumb, complete	31.95	NA	NA	19.90	21.91	4.54	20824
20827		A	Replantation thumb, complete	27.48	NA	NA	18.11	20.40	3.89	20827
20838		A	Replantation foot, complete	42.88	NA	NA	21.15	20.16	2.15	20838
20900		A	Removal of bone for graft	3.00	7.23	7.03	2.49	2.95	0.41	20900
20902		A	Removal of bone for graft	4.58	NA	NA	3.14	3.66	0.64	20902
20910		A	Remove cartilage for graft	5.53	NA	NA	5.23	5.06	0.50	20910
20912		A	Remove cartilage for graft	6.54	NA	NA	5.95	5.48	0.69	20912
20920		A	Removal of fascia for graft	5.51	NA	NA	4.88	4.54	0.50	20920
20922		A	Removal of fascia for graft	6.93	7.90	7.94	5.44	5.32	0.91	20922
20924		A	Removal of tendon for graft	6.68	NA	NA	5.96	5.57	0.85	20924

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20926		A	Removal of tissue for graft	5.79	NA	NA	5.20	4.83	0.83	20926
20930		B	Sp bone algrft morsel add-on	0.00	0.00	0.00	0.00	0.00	0.00	20930
20931		A	Sp bone algrft struct add-on	1.81	NA	NA	0.85	0.81	0.40	20931
20936		B	Sp bone agrft local add-on	0.00	0.00	0.00	0.00	0.00	0.00	20936
20937		A	Sp bone agrft morsel add-on	2.79	NA	NA	1.35	1.28	0.49	20937
20938		A	Sp bone agrft struct add-on	3.02	NA	NA	1.44	1.37	0.60	20938
20950		A	Fluid pressure, muscle	1.26	4.64	4.75	1.01	0.94	0.16	20950
20955		A	Fibula bone graft, microvasc	40.26	NA	NA	24.87	22.53	4.81	20955
20956		A	Iliac bone graft, microvasc	41.18	NA	NA	25.26	23.01	5.85	20956
20957		A	Mt bone graft, microvasc	42.61	NA	NA	26.46	19.82	6.05	20957
20962		A	Other bone graft, microvasc	39.21	NA	NA	27.43	24.09	5.61	20962
20969		A	Bone/skin graft, microvasc	45.43	NA	NA	27.57	24.66	4.80	20969
20970		A	Bone/skin graft, iliac crest	44.58	NA	NA	27.30	24.61	6.33	20970
20972		A	Bone/skin graft, metatarsal	44.51	NA	NA	14.55	17.22	2.46	20972
20973		A	Bone/skin graft, great toe	47.27	NA	NA	20.82	19.04	2.37	20973
20974		A	Electrical bone stimulation	0.62	1.20	1.01	0.60	0.54	0.10	20974
20975		A	Electrical bone stimulation	2.60	NA	NA	1.74	1.64	0.42	20975
20979		A	Us bone stimulation	0.62	0.70	0.67	0.23	0.24	0.06	20979
20982		A	Ablate, bone tumor(s) perq	7.27	75.64	85.22	2.48	2.85	0.59	20982
20985		A	Cptr-asst dir ms px	2.50	NA	NA	1.22	1.12	0.35	20985
20999		C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	0.00	0.00	20999
21010		A	Incision of jaw joint	11.04	NA	NA	8.98	7.26	1.01	21010
21011		A	Exc face les sc < 2 cm	2.99	5.18	5.18	3.33	3.33	0.32	21011
21012		A	Exc face les sc = 2 cm	4.45	NA	NA	4.12	4.12	0.52	21012
21013		A	Exc face tum deep < 2 cm	5.42	7.18	7.18	4.69	4.69	0.59	21013
21014		A	Exc face tum deep = 2 cm	7.13	NA	NA	6.09	6.09	0.82	21014
21015		A	Resect face tum < 2 cm	9.89	NA	NA	7.95	5.50	0.76	21015
21016		A	Resect face tum = 2 cm	15.26	NA	NA	10.90	10.90	2.07	21016
21025		A	Excision of bone, lower jaw	10.03	12.65	11.69	9.37	8.39	1.02	21025
21026		A	Excision of facial bone(s)	5.70	9.87	9.02	7.03	6.40	0.58	21026
21029		A	Contour of face bone lesion	8.39	11.03	10.08	7.95	7.15	1.17	21029
21030		A	Excise max/zygoma b9 tumor	4.91	8.07	7.35	5.69	5.11	0.55	21030
21031		A	Remove exostosis, mandible	3.30	6.54	6.05	4.21	3.79	0.30	21031
21032		A	Remove exostosis, maxilla	3.34	6.65	6.16	4.12	3.67	0.30	21032
21034		A	Excise max/zygoma mlg tumor	17.38	16.79	15.41	12.99	11.69	1.76	21034
21040		A	Excise mandible lesion	4.91	8.21	7.46	5.77	5.08	0.53	21040
21044		A	Removal of jaw bone lesion	12.80	NA	NA	10.25	9.15	1.26	21044
21045		A	Extensive jaw surgery	18.37	NA	NA	13.80	12.22	1.82	21045
21046		A	Remove mandible cyst complex	14.21	NA	NA	14.51	12.75	1.29	21046

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21047		A	Excise lwr jaw cyst w/repair	20.07	NA	NA	14.16	12.31	1.85	21047
21048		A	Remove maxilla cyst complex	14.71	NA	NA	14.76	12.74	1.34	21048
21049		A	Excis uppr jaw cyst w/repair	19.32	NA	NA	13.05	12.06	1.79	21049
21050		A	Removal of jaw joint	11.76	NA	NA	10.33	9.52	1.65	21050
21060		A	Remove jaw joint cartilage	11.07	NA	NA	10.04	8.54	1.70	21060
21070		A	Remove coronoid process	8.62	NA	NA	8.09	7.13	0.79	21070
21073		A	Mnpj of tmj w/anesth	3.45	5.99	5.64	3.17	2.58	0.47	21073
21076		A	Prepare face/oral prosthesis	13.40	11.66	10.11	8.56	7.00	1.24	21076
21077		A	Prepare face/oral prosthesis	33.70	27.75	24.33	21.66	18.07	3.14	21077
21079		A	Prepare face/oral prosthesis	22.31	19.96	17.44	14.49	11.93	2.08	21079
21080		A	Prepare face/oral prosthesis	25.06	22.65	19.94	16.00	13.28	2.34	21080
21081		A	Prepare face/oral prosthesis	22.85	20.88	18.38	14.71	12.20	2.13	21081
21082		A	Prepare face/oral prosthesis	20.84	20.44	17.63	14.38	11.68	1.95	21082
21083		A	Prepare face/oral prosthesis	19.27	19.93	17.32	13.42	10.86	0.97	21083
21084		A	Prepare face/oral prosthesis	22.48	22.51	19.82	15.37	12.70	2.10	21084
21085		A	Prepare face/oral prosthesis	8.99	9.14	7.92	5.93	4.92	2.42	21085
21086		A	Prepare face/oral prosthesis	24.88	19.98	17.26	15.85	12.90	2.32	21086
21087		A	Prepare face/oral prosthesis	24.88	19.78	17.23	15.61	12.88	2.32	21087
21088		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	21088
21089		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	21089
21100		A	Maxillofacial fixation	4.73	13.01	12.97	5.03	5.16	0.45	21100
21110		A	Interdental fixation	5.99	14.03	12.77	10.95	9.90	0.54	21110
21116		A	Injection, jaw joint x-ray	0.81	3.15	2.98	0.39	0.30	0.05	21116
21120		A	Reconstruction of chin	5.10	11.23	10.36	8.02	7.27	0.71	21120
21121		A	Reconstruction of chin	7.81	11.78	11.14	8.72	8.25	0.39	21121
21122		A	Reconstruction of chin	8.71	NA	NA	7.89	8.53	0.43	21122
21123		A	Reconstruction of chin	11.34	NA	NA	11.85	10.03	0.56	21123
21125		A	Augmentation, lower jaw bone	10.80	76.00	67.85	9.94	8.19	1.53	21125
21127		A	Augmentation, lower jaw bone	12.44	84.18	79.24	9.08	8.81	1.13	21127
21137		A	Reduction of forehead	10.24	NA	NA	9.00	7.60	1.45	21137
21138		A	Reduction of forehead	12.87	NA	NA	10.39	9.15	1.30	21138
21139		A	Reduction of forehead	15.02	NA	NA	9.26	9.57	0.75	21139
21141		A	Reconstruct midface, lefort	19.57	NA	NA	15.13	13.69	2.75	21141
21142		A	Reconstruct midface, lefort	20.28	NA	NA	16.37	13.11	2.86	21142
21143		A	Reconstruct midface, lefort	21.05	NA	NA	13.56	13.15	3.21	21143
21145		A	Reconstruct midface, lefort	23.94	NA	NA	18.24	14.69	1.18	21145
21146		A	Reconstruct midface, lefort	24.87	NA	NA	19.52	16.22	3.50	21146
21147		A	Reconstruct midface, lefort	26.47	NA	NA	18.62	16.32	1.31	21147
21150		A	Reconstruct midface, lefort	25.96	NA	NA	14.76	15.01	1.29	21150

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21151		A	Reconstruct midface, lefort	29.02	NA	NA	20.25	21.04	2.69	21151
21154		A	Reconstruct midface, lefort	31.29	NA	NA	21.71	19.95	2.89	21154
21155		A	Reconstruct midface, lefort	35.22	NA	NA	25.39	21.04	1.77	21155
21159		A	Reconstruct midface, lefort	43.14	NA	NA	27.42	24.07	3.99	21159
21160		A	Reconstruct midface, lefort	47.19	NA	NA	22.80	23.37	2.37	21160
21172		A	Reconstruct orbit/forehead	28.20	NA	NA	20.12	16.03	2.62	21172
21175		A	Reconstruct orbit/forehead	33.56	NA	NA	21.69	18.80	8.71	21175
21179		A	Reconstruct entire forehead	22.65	NA	NA	13.81	13.17	3.22	21179
21180		A	Reconstruct entire forehead	25.58	NA	NA	15.30	14.94	2.38	21180
21181		A	Contour cranial bone lesion	10.28	NA	NA	7.36	6.93	0.94	21181
21182		A	Reconstruct cranial bone	32.58	NA	NA	18.64	17.73	3.02	21182
21183		A	Reconstruct cranial bone	35.70	NA	NA	23.94	20.51	5.09	21183
21184		A	Reconstruct cranial bone	38.62	NA	NA	23.12	20.46	5.50	21184
21188		A	Reconstruction of midface	23.15	NA	NA	21.57	18.25	2.15	21188
21193		A	Reconst lwr jaw w/o graft	18.90	NA	NA	10.16	10.96	2.89	21193
21194		A	Reconst lwr jaw w/graft	21.82	NA	NA	14.49	13.33	2.01	21194
21195		A	Reconst lwr jaw w/o fixation	19.16	NA	NA	16.08	14.37	1.77	21195
21196		A	Reconst lwr jaw w/fixation	20.83	NA	NA	17.67	15.57	1.92	21196
21198		A	Reconstr lwr jaw segment	15.71	NA	NA	14.20	12.97	1.55	21198
21199		A	Reconstr lwr jaw w/advance	16.73	NA	NA	10.14	8.93	1.55	21199
21206		A	Reconstruct upper jaw bone	15.59	NA	NA	16.08	13.26	2.20	21206
21208		A	Augmentation of facial bones	11.42	36.47	32.55	10.19	9.22	1.59	21208
21209		A	Reduction of facial bones	7.82	14.99	12.87	9.71	8.32	1.08	21209
21210		A	Face bone graft	11.69	44.40	40.67	10.63	9.02	1.05	21210
21215		A	Lower jaw bone graft	12.23	85.88	78.01	11.01	9.25	1.71	21215
21230		A	Rib cartilage graft	11.17	NA	NA	9.15	7.84	1.58	21230
21235		A	Ear cartilage graft	7.50	11.02	10.49	7.22	6.67	0.77	21235
21240		A	Reconstruction of jaw joint	16.07	NA	NA	12.83	11.21	1.47	21240
21242		A	Reconstruction of jaw joint	14.59	NA	NA	11.84	10.54	1.33	21242
21243		A	Reconstruction of jaw joint	24.53	NA	NA	20.36	16.96	2.24	21243
21244		A	Reconstruction of lower jaw	13.62	NA	NA	13.97	12.56	1.37	21244
21245		A	Reconstruction of jaw	13.12	15.81	15.01	10.31	9.63	1.19	21245
21246		A	Reconstruction of jaw	12.92	NA	NA	8.91	8.10	1.18	21246
21247		A	Reconstruct lower jaw bone	24.37	NA	NA	16.29	15.24	3.43	21247
21248		A	Reconstruction of jaw	12.74	15.57	13.75	10.73	9.10	1.16	21248
21249		A	Reconstruction of jaw	18.77	20.18	17.62	14.71	12.02	1.74	21249
21255		A	Reconstruct lower jaw bone	18.46	NA	NA	16.42	16.55	1.70	21255
21256		A	Reconstruction of orbit	17.66	NA	NA	13.93	11.80	1.62	21256
21260		A	Revise eye sockets	17.90	NA	NA	12.21	14.29	0.89	21260

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21261		A	Revise eye sockets	34.07	NA	NA	23.50	21.47	4.83	21261
21263		A	Revise eye sockets	31.01	NA	NA	18.71	18.68	1.55	21263
21267		A	Revise eye sockets	20.69	NA	NA	20.36	18.14	2.92	21267
21268		A	Revise eye sockets	27.07	NA	NA	27.97	21.33	3.82	21268
21270		A	Augmentation, cheek bone	10.63	14.18	12.32	8.64	7.11	1.07	21270
21275		A	Revision, orbitofacial bones	11.76	NA	NA	9.71	8.28	1.66	21275
21280		A	Revision of eyelid	7.13	NA	NA	7.46	6.33	0.98	21280
21282		A	Revision of eyelid	4.27	NA	NA	5.36	4.66	0.55	21282
21295		A	Revision of jaw muscle/bone	1.90	NA	NA	2.60	2.48	0.26	21295
21296		A	Revision of jaw muscle/bone	4.78	NA	NA	6.58	5.94	0.43	21296
21299		C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	0.00	0.00	21299
21310		A	Treatment of nose fracture	0.58	2.35	2.12	0.14	0.13	0.07	21310
21315		A	Treatment of nose fracture	1.83	5.03	4.72	1.99	1.87	0.19	21315
21320		A	Treatment of nose fracture	1.88	4.60	4.34	1.65	1.52	0.19	21320
21325		A	Treatment of nose fracture	4.18	NA	NA	7.69	7.51	0.47	21325
21330		A	Treatment of nose fracture	5.79	NA	NA	8.65	8.39	0.53	21330
21335		A	Treatment of nose fracture	9.02	NA	NA	9.91	9.28	0.87	21335
21336		A	Treat nasal septal fracture	6.77	NA	NA	9.79	9.27	0.65	21336
21337		A	Treat nasal septal fracture	3.39	6.77	6.37	4.15	3.78	0.36	21337
21338		A	Treat nasoethmoid fracture	6.87	NA	NA	11.85	11.27	0.96	21338
21339		A	Treat nasoethmoid fracture	8.50	NA	NA	12.81	11.77	1.19	21339
21340		A	Treatment of nose fracture	11.49	NA	NA	8.38	8.21	1.05	21340
21343		A	Treatment of sinus fracture	14.32	NA	NA	16.48	14.45	2.02	21343
21344		A	Treatment of sinus fracture	21.57	NA	NA	18.13	15.63	5.56	21344
21345		A	Treat nose/jaw fracture	9.06	11.35	10.72	7.56	7.11	0.82	21345
21346		A	Treat nose/jaw fracture	11.45	NA	NA	12.33	11.95	1.04	21346
21347		A	Treat nose/jaw fracture	13.53	NA	NA	13.14	13.31	1.24	21347
21348		A	Treat nose/jaw fracture	17.52	NA	NA	11.42	10.51	1.62	21348
21355		A	Treat cheek bone fracture	4.45	6.70	6.41	4.02	3.68	0.40	21355
21356		A	Treat cheek bone fracture	4.83	7.71	7.30	4.83	4.45	0.51	21356
21360		A	Treat cheek bone fracture	7.19	NA	NA	6.65	5.97	0.65	21360
21365		A	Treat cheek bone fracture	16.77	NA	NA	12.06	10.56	2.01	21365
21366		A	Treat cheek bone fracture	18.60	NA	NA	14.21	11.57	2.64	21366
21385		A	Treat eye socket fracture	9.57	NA	NA	8.45	7.96	0.88	21385
21386		A	Treat eye socket fracture	9.57	NA	NA	7.01	6.68	1.34	21386
21387		A	Treat eye socket fracture	10.11	NA	NA	8.70	8.14	1.43	21387
21390		A	Treat eye socket fracture	11.23	NA	NA	9.29	8.04	1.35	21390
21395		A	Treat eye socket fracture	14.70	NA	NA	9.45	8.90	1.35	21395
21400		A	Treat eye socket fracture	1.50	3.16	2.92	2.32	2.12	0.18	21400

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21401		A	Treat eye socket fracture	3.68	8.02	7.91	3.84	3.61	0.51	21401
21406		A	Treat eye socket fracture	7.42	NA	NA	6.14	5.83	0.68	21406
21407		A	Treat eye socket fracture	9.02	NA	NA	7.66	6.77	1.14	21407
21408		A	Treat eye socket fracture	12.78	NA	NA	10.33	8.86	1.82	21408
21421		A	Treat mouth roof fracture	6.02	13.97	12.33	10.66	9.51	0.82	21421
21422		A	Treat mouth roof fracture	8.73	NA	NA	8.55	7.77	0.80	21422
21423		A	Treat mouth roof fracture	10.85	NA	NA	9.40	8.63	1.53	21423
21431		A	Treat craniofacial fracture	7.90	NA	NA	11.96	10.66	1.10	21431
21432		A	Treat craniofacial fracture	8.82	NA	NA	8.03	7.59	1.24	21432
21433		A	Treat craniofacial fracture	26.29	NA	NA	15.58	15.01	3.73	21433
21435		A	Treat craniofacial fracture	20.26	NA	NA	13.37	12.68	1.87	21435
21436		A	Treat craniofacial fracture	30.30	NA	NA	22.38	18.83	4.29	21436
21440		A	Treat dental ridge fracture	3.44	10.70	9.90	8.15	7.59	0.47	21440
21445		A	Treat dental ridge fracture	6.26	13.00	12.31	9.60	9.01	0.56	21445
21450		A	Treat lower jaw fracture	3.71	11.09	10.23	8.30	7.84	0.45	21450
21451		A	Treat lower jaw fracture	5.65	13.36	12.49	10.45	9.73	0.51	21451
21452		A	Treat lower jaw fracture	2.40	11.23	12.16	6.01	5.86	0.33	21452
21453		A	Treat lower jaw fracture	6.64	15.90	14.50	12.84	11.96	0.73	21453
21454		A	Treat lower jaw fracture	7.36	NA	NA	7.37	6.43	0.66	21454
21461		A	Treat lower jaw fracture	9.31	43.20	39.23	14.56	13.51	0.98	21461
21462		A	Treat lower jaw fracture	11.01	44.72	41.04	15.53	14.16	1.00	21462
21465		A	Treat lower jaw fracture	13.12	NA	NA	10.85	9.46	1.85	21465
21470		A	Treat lower jaw fracture	17.54	NA	NA	13.69	11.88	2.06	21470
21480		A	Reset dislocated jaw	0.61	1.67	1.62	0.23	0.19	0.07	21480
21485		A	Reset dislocated jaw	4.77	12.72	11.62	9.96	9.15	0.42	21485
21490		A	Repair dislocated jaw	12.95	NA	NA	10.71	9.55	1.82	21490
21495		A	Treat hyoid bone fracture	6.79	NA	NA	11.57	10.51	0.61	21495
21497		A	Interdental wiring	4.64	12.32	11.75	9.78	9.33	0.63	21497
21499		C	Head surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	21499
21501		A	Drain neck/chest lesion	3.98	7.32	6.82	4.12	3.81	0.53	21501
21502		A	Drain chest lesion	7.55	NA	NA	5.68	5.18	1.14	21502
21510		A	Drainage of bone lesion	6.20	NA	NA	4.75	4.94	1.02	21510
21550		A	Biopsy of neck/chest	2.11	4.30	4.20	1.88	1.83	0.22	21550
21552		A	Exc neck les sc = 3 cm	6.49	NA	NA	4.74	4.74	0.91	21552
21554		A	Exc neck tum deep = 5 cm	11.13	NA	NA	7.31	7.31	1.50	21554
21555		A	Exc neck les sc < 3 cm	3.96	6.30	5.97	3.77	3.57	0.63	21555
21556		A	Exc neck tum deep < 5 cm	7.66	NA	NA	5.78	4.66	0.76	21556
21557		A	Resect neck tum < 5 cm	14.75	NA	NA	9.67	6.16	1.21	21557
21558		A	Resect neck tum = 5 cm	21.58	NA	NA	12.92	12.92	2.93	21558

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21600		A	Partial removal of rib	7.26	NA	NA	6.86	6.26	1.11	21600
21610		A	Partial removal of rib	15.91	NA	NA	11.82	9.74	4.10	21610
21615		A	Removal of rib	10.45	NA	NA	5.97	5.75	1.78	21615
21616		A	Removal of rib and nerves	12.69	NA	NA	6.20	7.46	2.17	21616
21620		A	Partial removal of sternum	7.28	NA	NA	5.58	5.40	1.15	21620
21627		A	Sternal debridement	7.30	NA	NA	6.35	6.07	1.17	21627
21630		A	Extensive sternum surgery	19.18	NA	NA	12.23	11.58	2.90	21630
21632		A	Extensive sternum surgery	19.68	NA	NA	11.04	10.58	3.53	21632
21685		A	Hyoid myotomy & suspension	15.26	NA	NA	11.04	9.87	1.40	21685
21700		A	Revision of neck muscle	6.31	NA	NA	3.18	3.95	1.07	21700
21705		A	Revision of neck muscle/rib	9.92	NA	NA	4.23	5.22	1.70	21705
21720		A	Revision of neck muscle	5.80	NA	NA	4.86	4.19	1.49	21720
21725		A	Revision of neck muscle	7.19	NA	NA	6.19	5.64	1.01	21725
21740		A	Reconstruction of sternum	17.57	NA	NA	8.11	8.43	2.50	21740
21742		C	Repair stern/nuss w/o scope	0.00	0.00	0.00	0.00	0.00	0.00	21742
21743		C	Repair sternum/nuss w/scope	0.00	0.00	0.00	0.00	0.00	0.00	21743
21750		A	Repair of sternum separation	11.40	NA	NA	5.85	5.86	1.96	21750
21800		A	Treatment of rib fracture	1.01	1.64	1.44	1.71	1.49	0.12	21800
21805		A	Treatment of rib fracture	2.88	NA	NA	3.65	3.46	0.47	21805
21810		A	Treatment of rib fracture(s)	7.03	NA	NA	5.43	5.12	1.17	21810
21820		A	Treat sternum fracture	1.36	2.09	1.87	2.16	1.92	0.17	21820
21825		A	Treat sternum fracture	7.76	NA	NA	6.32	5.99	1.30	21825
21899		C	Neck/chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	21899
21920		A	Biopsy soft tissue of back	2.11	4.31	4.21	2.01	1.87	0.24	21920
21925		A	Biopsy soft tissue of back	4.63	6.14	5.63	4.02	3.60	0.67	21925
21930		A	Exc back les sc < 3 cm	4.94	6.61	6.23	4.13	3.89	0.75	21930
21931		A	Exc back les sc = 3 cm	6.88	NA	NA	4.82	4.82	1.01	21931
21932		A	Exc back tum deep < 5 cm	9.82	NA	NA	6.95	6.95	1.50	21932
21933		A	Exc back tum deep = 5 cm	11.13	NA	NA	7.31	7.31	1.71	21933
21935		A	Resect back tum < 5 cm	15.72	NA	NA	9.95	9.41	2.72	21935
21936		A	Resect back tum = 5 cm	22.55	NA	NA	13.14	13.14	3.30	21936
22010		A	I&d, p-spine, c/t/cerv-thor	12.75	NA	NA	9.98	9.16	2.36	22010
22015		A	I&d, p-spine, l/s/ls	12.64	NA	NA	10.01	9.17	2.19	22015
22100		A	Remove part of neck vertebra	11.00	NA	NA	9.58	8.56	2.81	22100
22101		A	Remove part, thorax vertebra	11.08	NA	NA	10.43	8.79	2.83	22101
22102		A	Remove part, lumbar vertebra	11.08	NA	NA	8.98	8.38	1.91	22102
22103		A	Remove extra spine segment	2.34	NA	NA	1.14	1.07	0.47	22103
22110		A	Remove part of neck vertebra	14.00	NA	NA	10.80	10.00	3.59	22110
22112		A	Remove part, thorax vertebra	14.07	NA	NA	11.83	9.71	3.61	22112

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22114		A	Remove part, lumbar vertebra	14.07	NA	NA	10.89	9.90	1.99	22114
22116		A	Remove extra spine segment	2.32	NA	NA	1.11	1.04	0.43	22116
22206		A	Cut spine 3 col, thor	37.18	NA	NA	21.93	19.79	5.29	22206
22207		A	Cut spine 3 col, lumb	36.68	NA	NA	21.87	19.64	6.63	22207
22208		A	Cut spine 3 col, addl seg	9.66	NA	NA	4.70	4.24	1.88	22208
22210		A	Revision of neck spine	25.38	NA	NA	17.29	15.99	4.85	22210
22212		A	Revision of thorax spine	20.99	NA	NA	15.15	13.79	3.55	22212
22214		A	Revision of lumbar spine	21.02	NA	NA	15.22	13.95	3.66	22214
22216		A	Revise, extra spine segment	6.03	NA	NA	2.93	2.77	1.08	22216
22220		A	Revision of neck spine	22.94	NA	NA	16.09	14.39	4.61	22220
22222		A	Revision of thorax spine	23.09	NA	NA	15.98	12.05	3.26	22222
22224		A	Revision of lumbar spine	23.09	NA	NA	15.66	14.31	3.85	22224
22226		A	Revise, extra spine segment	6.03	NA	NA	2.87	2.73	1.13	22226
22305		A	Treat spine process fracture	2.13	2.59	2.34	2.19	1.97	0.29	22305
22310		A	Treat spine fracture	3.89	3.66	3.21	3.10	2.71	0.54	22310
22315		A	Treat spine fracture	10.11	11.38	10.36	8.75	7.92	1.82	22315
22318		A	Treat odontoid fx w/o graft	22.72	NA	NA	15.42	14.19	5.53	22318
22319		A	Treat odontoid fx w/graft	25.33	NA	NA	16.86	15.16	6.54	22319
22325		A	Treat spine fracture	19.87	NA	NA	14.57	13.19	4.06	22325
22326		A	Treat neck spine fracture	20.84	NA	NA	14.45	13.21	4.54	22326
22327		A	Treat thorax spine fracture	20.77	NA	NA	14.93	13.44	4.01	22327
22328		A	Treat each add spine fx	4.60	NA	NA	2.21	2.06	0.97	22328
22505		A	Manipulation of spine	1.87	NA	NA	1.15	1.02	0.21	22505
22520		A	Percut vertebroplasty thor	9.22	44.19	47.16	3.88	4.40	0.76	22520
22521		A	Percut vertebroplasty lumb	8.65	44.12	46.50	3.73	4.21	0.72	22521
22522		A	Percut vertebroplasty addl	4.30	NA	NA	1.53	1.66	0.40	22522
22523		A	Percut kyphoplasty, thor	9.26	NA	NA	5.10	5.21	1.31	22523
22524		A	Percut kyphoplasty, lumbar	8.86	NA	NA	4.94	5.05	1.25	22524
22525		A	Percut kyphoplasty, add-on	4.47	NA	NA	1.94	1.96	0.68	22525
22526		N	Idet, single level	6.10	50.22	44.46	2.91	2.20	0.39	22526
22527		N	Idet, 1 or more levels	3.03	43.14	37.03	1.11	0.72	0.17	22527
22532		A	Lat thorax spine fusion	25.99	NA	NA	16.84	15.27	5.45	22532
22533		A	Lat lumbar spine fusion	24.79	NA	NA	16.39	14.78	4.60	22533
22534		A	Lat thor/lumb, addl seg	5.99	NA	NA	2.87	2.71	1.15	22534
22548		A	Neck spine fusion	27.06	NA	NA	17.89	16.22	7.00	22548
22554		A	Neck spine fusion	17.69	NA	NA	12.55	11.78	3.93	22554
22556		A	Thorax spine fusion	24.70	NA	NA	15.58	14.43	4.77	22556
22558		A	Lumbar spine fusion	23.53	NA	NA	14.35	13.07	4.06	22558
22585		A	Additional spinal fusion	5.52	NA	NA	2.60	2.45	1.15	22585

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22590		A	Spine & skull spinal fusion	21.76	NA	NA	15.39	14.13	5.08	22590
22595		A	Neck spinal fusion	20.64	NA	NA	14.82	13.57	4.72	22595
22600		A	Neck spine fusion	17.40	NA	NA	13.15	12.02	3.81	22600
22610		A	Thorax spine fusion	17.28	NA	NA	12.92	11.85	3.48	22610
22612		A	Lumbar spine fusion	23.53	NA	NA	15.20	14.02	4.49	22612
22614		A	Spine fusion, extra segment	6.43	NA	NA	3.08	2.93	1.27	22614
22630		A	Lumbar spine fusion	22.09	NA	NA	15.06	13.83	4.52	22630
22632		A	Spine fusion, extra segment	5.22	NA	NA	2.50	2.36	1.08	22632
22800		A	Fusion of spine	19.50	NA	NA	13.61	12.55	3.51	22800
22802		A	Fusion of spine	32.11	NA	NA	19.67	18.41	5.42	22802
22804		A	Fusion of spine	37.50	NA	NA	22.21	20.86	6.14	22804
22808		A	Fusion of spine	27.51	NA	NA	16.79	15.71	5.24	22808
22810		A	Fusion of spine	31.50	NA	NA	18.40	16.97	5.71	22810
22812		A	Fusion of spine	34.25	NA	NA	21.30	19.24	4.86	22812
22818		A	Kyphectomy, 1-2 segments	34.33	NA	NA	20.31	18.58	4.88	22818
22819		A	Kyphectomy, 3 or more	39.38	NA	NA	24.03	21.61	10.20	22819
22830		A	Exploration of spinal fusion	11.22	NA	NA	8.47	7.83	2.08	22830
22840		A	Insert spine fixation device	12.52	NA	NA	6.02	5.69	2.52	22840
22841		B	Insert spine fixation device	0.00	0.00	0.00	0.00	0.00	0.00	22841
22842		A	Insert spine fixation device	12.56	NA	NA	6.03	5.71	2.49	22842
22843		A	Insert spine fixation device	13.44	NA	NA	6.46	6.07	2.53	22843
22844		A	Insert spine fixation device	16.42	NA	NA	8.01	7.66	2.67	22844
22845		A	Insert spine fixation device	11.94	NA	NA	5.67	5.35	2.64	22845
22846		A	Insert spine fixation device	12.40	NA	NA	5.89	5.55	2.73	22846
22847		A	Insert spine fixation device	13.78	NA	NA	6.42	6.17	3.58	22847
22848		A	Insert pelv fixation device	5.99	NA	NA	2.93	2.80	1.00	22848
22849		A	Reinsert spinal fixation	19.17	NA	NA	12.41	11.48	3.71	22849
22850		A	Remove spine fixation device	9.82	NA	NA	7.64	7.04	1.89	22850
22851		A	Apply spine prosth device	6.70	NA	NA	3.20	3.01	1.37	22851
22852		A	Remove spine fixation device	9.37	NA	NA	7.39	6.80	1.75	22852
22855		A	Remove spine fixation device	15.86	NA	NA	10.88	10.00	3.42	22855
22856		A	Cerv artific diskectomy	24.05	NA	NA	15.31	14.28	5.26	22856
22857		R	Lumbar artif diskectomy	27.13	NA	NA	13.74	13.98	4.17	22857
22861		A	Revise cerv artific disc	33.36	NA	NA	14.52	14.02	1.68	22861
22862		R	Revise lumbar artif disc	32.63	NA	NA	15.77	14.47	4.64	22862
22864		A	Remove cerv artif disc	29.40	NA	NA	13.08	12.64	1.48	22864
22865		R	Remove lumb artif disc	31.75	NA	NA	19.72	18.91	4.51	22865
22899		C	Spine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	22899
22900		A	Exc back tum deep < 5 cm	8.32	NA	NA	5.68	4.13	0.92	22900

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22901		A	Exc back tum deep = 5 cm	10.11	NA	NA	6.36	6.36	1.51	22901
22902		A	Exc abd les sc < 3 cm	4.42	6.41	6.41	4.14	4.14	0.51	22902
22903		A	Exc abd les sc > 3 cm	6.39	NA	NA	4.63	4.63	0.86	22903
22904		A	Resect abd tum < 5 cm	16.69	NA	NA	8.91	8.91	2.56	22904
22905		A	Resect abd tum > 5 cm	21.58	NA	NA	11.62	11.62	3.30	22905
22999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	22999
23000		A	Removal of calcium deposits	4.48	9.47	8.58	4.61	4.21	0.62	23000
23020		A	Release shoulder joint	9.36	NA	NA	7.85	7.26	1.27	23020
23030		A	Drain shoulder lesion	3.47	7.13	6.78	2.84	2.67	0.49	23030
23031		A	Drain shoulder bursa	2.79	6.95	6.62	2.49	2.33	0.38	23031
23035		A	Drain shoulder bone lesion	9.16	NA	NA	7.74	7.31	1.28	23035
23040		A	Exploratory shoulder surgery	9.75	NA	NA	8.13	7.54	1.36	23040
23044		A	Exploratory shoulder surgery	7.59	NA	NA	6.69	6.18	1.06	23044
23065		A	Biopsy shoulder tissues	2.30	3.11	2.94	1.94	1.81	0.28	23065
23066		A	Biopsy shoulder tissues	4.30	8.94	8.13	4.36	3.95	0.60	23066
23071		A	Exc shoulder les sc > 3 cm	5.91	NA	NA	4.52	4.52	0.86	23071
23073		A	Exc shoulder tum deep > 5 cm	10.13	NA	NA	7.11	7.11	1.48	23073
23075		A	Exc shoulder les sc < 3 cm	4.21	7.06	4.59	3.92	2.34	0.36	23075
23076		A	Exc shoulder tum deep < 5 cm	7.41	NA	NA	5.88	5.63	1.14	23076
23077		A	Resect shoulder tum < 5 cm	17.66	NA	NA	11.18	10.44	2.67	23077
23078		A	Resect shoulder tum > 5 cm	22.55	NA	NA	11.98	11.98	3.45	23078
23100		A	Biopsy of shoulder joint	6.20	NA	NA	6.13	5.58	0.86	23100
23101		A	Shoulder joint surgery	5.72	NA	NA	5.36	5.04	0.79	23101
23105		A	Remove shoulder joint lining	8.48	NA	NA	7.30	6.81	1.18	23105
23106		A	Incision of collarbone joint	6.13	NA	NA	6.09	5.43	0.85	23106
23107		A	Explore treat shoulder joint	8.87	NA	NA	7.54	7.01	1.23	23107
23120		A	Partial removal, collar bone	7.39	NA	NA	7.12	6.51	1.02	23120
23125		A	Removal of collar bone	9.64	NA	NA	7.94	7.26	1.35	23125
23130		A	Remove shoulder bone, part	7.77	NA	NA	7.27	6.77	1.08	23130
23140		A	Removal of bone lesion	7.12	NA	NA	5.82	5.28	1.00	23140
23145		A	Removal of bone lesion	9.40	NA	NA	7.82	7.23	1.32	23145
23146		A	Removal of bone lesion	8.08	NA	NA	7.26	6.45	1.13	23146
23150		A	Removal of humerus lesion	8.91	NA	NA	7.52	6.91	1.23	23150
23155		A	Removal of humerus lesion	10.86	NA	NA	8.81	8.14	1.53	23155
23156		A	Removal of humerus lesion	9.11	NA	NA	7.68	7.08	1.28	23156
23170		A	Remove collar bone lesion	7.21	NA	NA	6.62	5.71	1.01	23170
23172		A	Remove shoulder blade lesion	7.31	NA	NA	6.67	5.96	1.02	23172
23174		A	Remove humerus lesion	10.05	NA	NA	8.72	8.08	1.42	23174
23180		A	Remove collar bone lesion	8.99	NA	NA	7.57	7.40	1.28	23180

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23182		A	Remove shoulder blade lesion	8.61	NA	NA	7.80	7.34	1.20	23182
23184		A	Remove humerus lesion	9.90	NA	NA	8.38	7.99	1.36	23184
23190		A	Partial removal of scapula	7.47	NA	NA	6.66	6.00	1.05	23190
23195		A	Removal of head of humerus	10.36	NA	NA	8.38	7.72	1.46	23195
23200		A	Resect clavicle tumor	22.71	NA	NA	15.21	10.03	1.82	23200
23210		A	Resect scapula tumor	27.21	NA	NA	17.41	10.97	1.89	23210
23220		A	Resect prox humerus tumor	30.21	NA	NA	18.64	12.16	2.20	23220
23330		A	Remove shoulder foreign body	1.90	4.00	3.63	1.92	1.74	0.26	23330
23331		A	Remove shoulder foreign body	7.63	NA	NA	7.01	6.51	1.06	23331
23332		A	Remove shoulder foreign body	12.37	NA	NA	9.64	8.95	1.73	23332
23350		A	Injection for shoulder x-ray	1.00	2.51	2.86	0.32	0.36	0.07	23350
23395		A	Muscle transfer,shoulder/arm	18.54	NA	NA	13.65	12.58	2.58	23395
23397		A	Muscle transfers	16.76	NA	NA	11.69	10.89	2.38	23397
23400		A	Fixation of shoulder blade	13.87	NA	NA	10.29	9.62	1.97	23400
23405		A	Incision of tendon & muscle	8.54	NA	NA	7.14	6.64	1.19	23405
23406		A	Incise tendon(s) & muscle(s)	11.01	NA	NA	8.36	7.84	1.56	23406
23410		A	Repair rotator cuff, acute	11.39	NA	NA	9.09	8.54	1.59	23410
23412		A	Repair rotator cuff, chronic	11.93	NA	NA	9.37	8.84	1.68	23412
23415		A	Release of shoulder ligament	9.23	NA	NA	7.98	7.47	1.28	23415
23420		A	Repair of shoulder	13.54	NA	NA	10.63	9.96	1.91	23420
23430		A	Repair biceps tendon	10.17	NA	NA	8.20	7.63	1.42	23430
23440		A	Remove/transplant tendon	10.64	NA	NA	8.23	7.67	1.49	23440
23450		A	Repair shoulder capsule	13.70	NA	NA	9.93	9.22	1.95	23450
23455		A	Repair shoulder capsule	14.67	NA	NA	10.41	9.73	2.06	23455
23460		A	Repair shoulder capsule	15.82	NA	NA	11.34	10.62	2.25	23460
23462		A	Repair shoulder capsule	15.72	NA	NA	11.01	10.23	2.24	23462
23465		A	Repair shoulder capsule	16.30	NA	NA	11.51	10.74	2.32	23465
23466		A	Repair shoulder capsule	15.80	NA	NA	12.27	11.25	2.22	23466
23470		A	Reconstruct shoulder joint	17.89	NA	NA	12.38	11.53	2.52	23470
23472		A	Reconstruct shoulder joint	22.65	NA	NA	14.89	13.81	3.18	23472
23480		A	Revision of collar bone	11.54	NA	NA	8.87	8.22	1.63	090
23485		A	Revision of collar bone	13.91	NA	NA	10.03	9.36	1.96	090
23490		A	Reinforce clavicle	12.16	NA	NA	9.27	8.42	1.73	090
23491		A	Reinforce shoulder bones	14.54	NA	NA	10.75	9.99	2.07	090
23500		A	Treat clavicle fracture	2.21	3.12	2.84	3.20	2.84	0.29	090
23505		A	Treat clavicle fracture	3.83	4.78	4.36	4.33	3.92	0.52	090
23515		A	Treat clavicle fracture	9.69	NA	NA	8.45	7.53	1.35	090
23520		A	Treat clavicle dislocation	2.29	3.33	2.96	3.41	3.00	0.31	090
23525		A	Treat clavicle dislocation	3.79	5.56	4.56	4.89	3.99	0.52	090

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
23530		A	Treat clavicle dislocation	7.48	NA	NA	6.66	5.65	1.05	090
23532		A	Treat clavicle dislocation	8.20	NA	NA	7.23	6.70	1.15	090
23540		A	Treat clavicle dislocation	2.36	3.09	2.82	3.17	2.79	0.30	090
23545		A	Treat clavicle dislocation	3.43	4.52	4.11	3.83	3.49	0.42	090
23550		A	Treat clavicle dislocation	7.59	NA	NA	6.59	6.15	1.04	090
23552		A	Treat clavicle dislocation	8.82	NA	NA	7.56	7.00	1.22	090
23570		A	Treat shoulder blade fx	2.36	3.30	3.01	3.46	3.11	0.32	090
23575		A	Treat shoulder blade fx	4.23	5.54	4.96	4.96	4.42	0.59	090
23585		A	Treat scapula fracture	14.23	NA	NA	10.41	9.17	1.99	090
23600		A	Treat humerus fracture	3.11	4.79	4.41	4.32	3.87	0.42	090
23605		A	Treat humerus fracture	5.06	6.33	5.88	5.44	5.01	0.69	090
23615		A	Treat humerus fracture	12.30	NA	NA	9.79	8.95	1.73	090
23616		A	Treat humerus fracture	18.37	NA	NA	12.80	12.19	2.58	090
23620		A	Treat humerus fracture	2.55	4.02	3.66	3.72	3.32	0.34	090
23625		A	Treat humerus fracture	4.10	5.23	4.81	4.64	4.24	0.55	090
23630		A	Treat humerus fracture	10.57	NA	NA	8.92	7.89	1.48	090
23650		A	Treat shoulder dislocation	3.53	3.88	3.54	3.33	2.95	0.43	090
23655		A	Treat shoulder dislocation	4.76	NA	NA	4.98	4.47	0.63	090
23660		A	Treat shoulder dislocation	7.66	NA	NA	6.85	6.29	1.06	090
23665		A	Treat dislocation/fracture	4.66	5.77	5.28	5.10	4.67	0.63	090
23670		A	Treat dislocation/fracture	12.28	NA	NA	9.64	8.45	1.73	090
23675		A	Treat dislocation/fracture	6.27	7.13	6.60	6.00	5.58	0.84	090
23680		A	Treat dislocation/fracture	13.15	NA	NA	10.03	9.01	1.85	090
23700		A	Fixation of shoulder	2.57	NA	NA	2.27	2.10	0.35	010
23800		A	Fusion of shoulder joint	14.73	NA	NA	10.80	10.04	2.09	090
23802		A	Fusion of shoulder joint	18.42	NA	NA	13.57	12.03	2.60	090
23900		A	Amputation of arm & girdle	20.72	NA	NA	13.95	11.66	2.94	090
23920		A	Amputation at shoulder joint	16.23	NA	NA	11.85	10.13	2.30	090
23921		A	Amputation follow-up surgery	5.72	NA	NA	4.80	4.00	0.96	090
23929		C	Shoulder surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23930		A	Drainage of arm lesion	2.99	5.70	5.51	2.39	2.22	0.43	010
23931		A	Drainage of arm bursa	1.84	5.00	4.86	2.09	1.96	0.25	010
23935		A	Drain arm/elbow bone lesion	6.38	NA	NA	5.98	5.55	0.88	090
24000		A	Exploratory elbow surgery	6.08	NA	NA	5.73	5.28	0.83	090
24006		A	Release elbow joint	9.74	NA	NA	7.99	7.39	1.29	090
24065		A	Biopsy arm/elbow soft tissue	2.13	4.19	4.05	2.10	1.98	0.25	010
24066		A	Biopsy arm/elbow soft tissue	5.35	9.62	8.87	4.80	4.28	0.76	090
24071		A	Exc arm/elbow les sc = 3 cm	5.70	NA	NA	4.44	4.44	0.82	090
24073		A	Ex arm/elbow tum deep > 5 cm	10.13	NA	NA	7.23	7.23	1.45	090

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24075		A	Exc arm/elbow les sc < 3 cm	4.24	7.55	7.40	3.99	3.56	0.57	090
24076		A	Ex arm/elbow tum deep < 5 cm	7.41	NA	NA	6.03	5.13	0.92	090
24077		A	Resect arm/elbow tum < 5 cm	15.72	NA	NA	10.27	8.08	1.76	090
24079		A	Resect arm/elbow tum > 5 cm	20.61	NA	NA	11.26	11.26	3.15	090
24100		A	Biopsy elbow joint lining	5.07	NA	NA	5.20	4.68	0.71	090
24101		A	Explore/treat elbow joint	6.30	NA	NA	6.04	5.64	0.86	090
24102		A	Remove elbow joint lining	8.26	NA	NA	7.06	6.51	1.10	090
24105		A	Removal of elbow bursa	3.78	NA	NA	4.79	4.38	0.51	090
24110		A	Remove humerus lesion	7.58	NA	NA	6.93	6.40	1.06	090
24115		A	Remove/graft bone lesion	10.12	NA	NA	6.91	7.14	1.43	090
24116		A	Remove/graft bone lesion	12.23	NA	NA	9.21	8.52	1.74	090
24120		A	Remove elbow lesion	6.82	NA	NA	6.23	5.73	0.93	090
24125		A	Remove/graft bone lesion	8.14	NA	NA	7.20	6.53	1.14	090
24126		A	Remove/graft bone lesion	8.62	NA	NA	7.44	6.87	1.21	090
24130		A	Removal of head of radius	6.42	NA	NA	6.18	5.72	0.85	090
24134		A	Removal of arm bone lesion	10.22	NA	NA	8.31	7.85	1.44	090
24136		A	Remove radius bone lesion	8.40	NA	NA	7.21	6.09	1.18	090
24138		A	Remove elbow bone lesion	8.50	NA	NA	8.15	7.51	1.18	090
24140		A	Partial removal of arm bone	9.55	NA	NA	7.99	7.67	1.26	090
24145		A	Partial removal of radius	7.81	NA	NA	6.82	6.62	1.09	090
24147		A	Partial removal of elbow	7.84	NA	NA	7.52	7.23	1.07	090
24149		A	Radical resection of elbow	16.22	NA	NA	13.16	11.92	2.12	090
24150		A	Resect distal humerus tumor	23.46	NA	NA	15.48	10.87	1.97	090
24152		A	Resect radius tumor	19.99	NA	NA	13.78	8.90	1.46	090
24155		A	Removal of elbow joint	12.09	NA	NA	9.13	8.38	1.72	090
24160		A	Remove elbow joint implant	8.00	NA	NA	7.05	6.54	1.07	090
24164		A	Remove radius head implant	6.43	NA	NA	5.86	5.46	0.90	090
24200		A	Removal of arm foreign body	1.81	3.21	3.00	1.68	1.51	0.23	010
24201		A	Removal of arm foreign body	4.70	8.91	8.56	4.37	4.05	0.66	090
24220		A	Injection for elbow x-ray	1.31	2.60	2.93	0.46	0.50	0.09	000
24300		A	Manipulate elbow w/anesth	4.04	NA	NA	5.96	5.54	0.50	090
24301		A	Muscle/tendon transfer	10.38	NA	NA	8.28	7.73	1.47	090
24305		A	Arm tendon lengthening	7.62	NA	NA	6.83	6.33	0.97	090
24310		A	Revision of arm tendon	6.12	NA	NA	5.73	5.30	0.84	090
24320		A	Repair of arm tendon	10.86	NA	NA	8.53	7.82	1.54	090
24330		A	Revision of arm muscles	9.79	NA	NA	8.00	7.43	1.37	090
24331		A	Revision of arm muscles	10.95	NA	NA	8.57	8.04	1.55	090
24332		A	Tenolysis, triceps	7.91	NA	NA	7.22	6.67	1.10	090
24340		A	Repair of biceps tendon	8.08	NA	NA	7.13	6.63	1.13	090

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24341		A	Repair arm tendon/muscle	9.49	NA	NA	9.06	8.20	1.29	090
24342		A	Repair of ruptured tendon	10.86	NA	NA	8.57	7.98	1.49	090
24343		A	Repr elbow lat ligmnt w/tiss	9.16	NA	NA	8.50	7.83	1.19	090
24344		A	Reconstruct elbow lat ligmnt	15.21	NA	NA	12.07	11.12	2.15	090
24345		A	Repr elbw med ligmnt w/tissu	9.16	NA	NA	8.37	7.70	1.20	090
24346		A	Reconstruct elbow med ligmnt	15.21	NA	NA	12.07	11.18	2.15	090
24357		A	Repair elbow, perc	5.44	NA	NA	5.62	5.23	0.73	090
24358		A	Repair elbow w/deb, open	6.66	NA	NA	6.33	5.87	0.88	090
24359		A	Repair elbow deb/attch open	8.98	NA	NA	7.48	6.76	1.20	090
24360		A	Reconstruct elbow joint	12.67	NA	NA	9.68	9.03	1.80	090
24361		A	Reconstruct elbow joint	14.41	NA	NA	10.63	9.97	2.05	090
24362		A	Reconstruct elbow joint	15.32	NA	NA	11.07	10.29	2.18	090
24363		A	Replace elbow joint	22.65	NA	NA	15.08	13.74	3.03	090
24365		A	Reconstruct head of radius	8.62	NA	NA	7.21	6.74	1.21	090
24366		A	Reconstruct head of radius	9.36	NA	NA	7.62	7.09	1.25	090
24400		A	Revision of humerus	11.33	NA	NA	9.11	8.48	1.57	090
24410		A	Revision of humerus	15.11	NA	NA	11.20	10.16	2.14	090
24420		A	Revision of humerus	13.73	NA	NA	10.88	10.12	1.95	090
24430		A	Repair of humerus	15.25	NA	NA	11.26	10.22	2.11	090
24435		A	Repair humerus with graft	14.99	NA	NA	11.93	10.91	2.08	090
24470		A	Revision of elbow joint	8.93	NA	NA	7.67	6.42	1.25	090
24495		A	Decompression of forearm	8.41	NA	NA	7.48	7.41	1.27	090
24498		A	Reinforce humerus	12.28	NA	NA	9.29	8.69	1.74	090
24500		A	Treat humerus fracture	3.41	5.26	4.81	4.53	4.04	0.45	090
24505		A	Treat humerus fracture	5.39	6.86	6.35	5.76	5.31	0.73	090
24515		A	Treat humerus fracture	12.12	NA	NA	9.72	9.01	1.70	090
24516		A	Treat humerus fracture	12.19	NA	NA	9.28	8.63	1.73	090
24530		A	Treat humerus fracture	3.69	5.58	5.12	4.75	4.28	0.49	090
24535		A	Treat humerus fracture	7.11	8.08	7.49	6.99	6.44	0.97	090
24538		A	Treat humerus fracture	9.77	NA	NA	8.58	8.08	1.37	090
24545		A	Treat humerus fracture	13.15	NA	NA	10.06	9.08	1.84	090
24546		A	Treat humerus fracture	14.91	NA	NA	11.07	10.38	2.07	090
24560		A	Treat humerus fracture	2.98	4.83	4.42	4.06	3.59	0.39	090
24565		A	Treat humerus fracture	5.78	7.24	6.39	6.22	5.45	0.80	090
24566		A	Treat humerus fracture	9.06	NA	NA	8.64	7.96	1.26	090
24575		A	Treat humerus fracture	9.71	NA	NA	8.50	7.92	1.33	090
24576		A	Treat humerus fracture	3.06	5.22	4.74	4.42	3.94	0.41	090
24577		A	Treat humerus fracture	6.01	7.41	6.63	6.33	5.61	0.83	090
24579		A	Treat humerus fracture	11.44	NA	NA	9.38	8.65	1.58	090

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24582		A	Treat humerus fracture	10.14	NA	NA	9.81	8.91	1.41	090
24586		A	Treat elbow fracture	15.78	NA	NA	11.34	10.60	2.18	090
24587		A	Treat elbow fracture	15.79	NA	NA	11.52	10.61	2.10	090
24600		A	Treat elbow dislocation	4.37	4.49	4.20	3.82	3.45	0.55	090
24605		A	Treat elbow dislocation	5.64	NA	NA	5.87	5.37	0.77	090
24615		A	Treat elbow dislocation	9.83	NA	NA	7.93	7.38	1.31	090
24620		A	Treat elbow fracture	7.22	NA	NA	6.35	5.98	0.95	090
24635		A	Treat elbow fracture	8.80	NA	NA	7.93	8.56	1.19	090
24640		A	Treat elbow dislocation	1.25	1.97	1.68	0.98	0.85	0.15	010
24650		A	Treat radius fracture	2.31	4.04	3.70	3.55	3.14	0.30	090
24655		A	Treat radius fracture	4.62	6.11	5.64	5.21	4.76	0.61	090
24665		A	Treat radius fracture	8.36	NA	NA	7.82	7.24	1.13	090
24666		A	Treat radius fracture	9.86	NA	NA	8.42	7.78	1.32	090
24670		A	Treat ulnar fracture	2.69	4.37	4.03	3.72	3.35	0.35	090
24675		A	Treat ulnar fracture	4.91	6.23	5.82	5.31	4.94	0.66	090
24685		A	Treat ulnar fracture	8.37	NA	NA	7.85	7.25	1.15	090
24800		A	Fusion of elbow joint	11.41	NA	NA	9.17	7.99	1.61	090
24802		A	Fusion/graft of elbow joint	14.32	NA	NA	10.60	9.78	2.03	090
24900		A	Amputation of upper arm	10.18	NA	NA	7.95	7.21	1.45	090
24920		A	Amputation of upper arm	10.13	NA	NA	8.05	7.12	1.43	090
24925		A	Amputation follow-up surgery	7.30	NA	NA	6.66	6.14	1.02	090
24930		A	Amputation follow-up surgery	10.83	NA	NA	8.39	7.46	1.53	090
24931		A	Amputate upper arm & implant	13.44	NA	NA	7.04	6.71	0.67	090
24935		A	Revision of amputation	16.45	NA	NA	12.22	9.05	2.33	090
24940		C	Revision of upper arm	0.00	0.00	0.00	0.00	0.00	0.00	090
24999		C	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
25000		A	Incision of tendon sheath	3.55	NA	NA	4.72	4.82	0.45	090
25001		A	Incise flexor carpi radialis	3.79	NA	NA	4.68	4.27	0.47	090
25020		A	Decompress forearm 1 space	6.06	NA	NA	8.14	7.84	0.75	090
25023		A	Decompress forearm 1 space	13.83	NA	NA	14.02	12.86	1.96	090
25024		A	Decompress forearm 2 spaces	10.79	NA	NA	8.46	7.88	1.51	090
25025		A	Decompress forearm 2 spaces	17.94	NA	NA	12.63	11.11	2.54	090
25028		A	Drainage of forearm lesion	5.39	NA	NA	7.38	7.04	0.73	090
25031		A	Drainage of forearm bursa	4.26	NA	NA	4.68	4.75	0.59	090
25035		A	Treat forearm bone lesion	7.65	NA	NA	6.52	7.51	1.04	090
25040		A	Explore/treat wrist joint	7.50	NA	NA	6.50	6.23	0.97	090
25065		A	Biopsy forearm soft tissues	2.04	4.26	4.11	2.12	2.02	0.23	010
25066		A	Biopsy forearm soft tissues	4.27	NA	NA	4.52	4.72	0.57	090
25071		A	Exc forearm les sc > 3 cm	5.91	NA	NA	4.74	4.74	0.83	090

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25073		A	Exc forearm tum deep = 3 cm	7.13	NA	NA	6.20	6.20	0.96	090
25075		A	Exc forearm les sc < 3 cm	3.96	7.56	4.96	3.96	4.04	0.54	090
25076		A	Exc forearm tum deep < 3 cm	6.74	NA	NA	6.02	5.74	0.68	090
25077		A	Resect forearm/wrist tum<3cm	12.93	NA	NA	9.12	8.23	1.45	090
25078		A	Resect forearm/wrist tum=3cm	17.69	NA	NA	10.18	10.18	2.71	090
25085		A	Incision of wrist capsule	5.64	NA	NA	5.48	5.44	0.79	090
25100		A	Biopsy of wrist joint	4.02	NA	NA	4.47	4.30	0.56	090
25101		A	Explore/treat wrist joint	4.83	NA	NA	5.17	4.94	0.64	090
25105		A	Remove wrist joint lining	6.02	NA	NA	6.00	5.82	0.78	090
25107		A	Remove wrist joint cartilage	7.70	NA	NA	7.66	7.25	0.96	090
25109		A	Excise tendon forearm/wrist	6.94	NA	NA	6.47	5.80	0.88	090
25110		A	Remove wrist tendon lesion	4.04	NA	NA	4.35	4.55	0.54	090
25111		A	Remove wrist tendon lesion	3.53	NA	NA	4.32	4.09	0.47	090
25112		A	Reremove wrist tendon lesion	4.67	NA	NA	4.83	4.57	0.62	090
25115		A	Remove wrist/forearm lesion	10.09	NA	NA	8.91	9.25	1.27	090
25116		A	Remove wrist/forearm lesion	7.56	NA	NA	7.41	7.98	0.94	090
25118		A	Excise wrist tendon sheath	4.51	NA	NA	4.94	4.75	0.57	090
25119		A	Partial removal of ulna	6.21	NA	NA	6.04	5.94	0.87	090
25120		A	Removal of forearm lesion	6.27	NA	NA	6.06	6.82	0.83	090
25125		A	Remove/graft forearm lesion	7.67	NA	NA	6.97	7.68	1.07	090
25126		A	Remove/graft forearm lesion	7.74	NA	NA	7.00	7.65	1.08	090
25130		A	Removal of wrist lesion	5.43	NA	NA	5.69	5.44	0.69	090
25135		A	Remove & graft wrist lesion	7.08	NA	NA	7.05	6.53	0.99	090
25136		A	Remove & graft wrist lesion	6.14	NA	NA	6.00	5.74	0.86	090
25145		A	Remove forearm bone lesion	6.54	NA	NA	6.20	6.93	0.91	090
25150		A	Partial removal of ulna	7.38	NA	NA	6.63	6.51	0.97	090
25151		A	Partial removal of radius	7.68	NA	NA	6.90	7.50	1.08	090
25170		A	Resect radius/ulnar tumor	22.21	NA	NA	14.77	11.07	1.62	090
25210		A	Removal of wrist bone	6.12	NA	NA	6.06	5.78	0.76	090
25215		A	Removal of wrist bones	8.14	NA	NA	7.31	7.08	1.00	090
25230		A	Partial removal of radius	5.37	NA	NA	5.39	5.15	0.64	090
25240		A	Partial removal of ulna	5.31	NA	NA	5.37	5.30	0.66	090
25246		A	Injection for wrist x-ray	1.45	2.52	2.84	0.49	0.54	0.11	000
25248		A	Remove forearm foreign body	5.31	NA	NA	4.91	5.21	0.74	090
25250		A	Removal of wrist prosthesis	6.77	NA	NA	6.30	5.86	0.95	090
25251		A	Removal of wrist prosthesis	9.82	NA	NA	8.01	7.46	1.39	090
25259		A	Manipulate wrist w/anesthes	4.04	NA	NA	6.01	5.59	0.51	090
25260		A	Repair forearm tendon/muscle	8.04	NA	NA	7.63	8.18	1.05	090
25263		A	Repair forearm tendon/muscle	8.04	NA	NA	7.43	8.10	1.12	090

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25265		A	Repair forearm tendon/muscle	10.10	NA	NA	8.44	9.04	1.42	090
25270		A	Repair forearm tendon/muscle	6.17	NA	NA	6.06	6.76	0.81	090
25272		A	Repair forearm tendon/muscle	7.21	NA	NA	6.55	7.31	0.94	090
25274		A	Repair forearm tendon/muscle	8.94	NA	NA	7.59	8.28	1.25	090
25275		A	Repair forearm tendon sheath	8.96	NA	NA	7.73	7.25	1.25	090
25280		A	Revise wrist/forearm tendon	7.39	NA	NA	6.75	7.39	0.92	090
25290		A	Incise wrist/forearm tendon	5.43	NA	NA	5.39	6.87	0.69	090
25295		A	Release wrist/forearm tendon	6.72	NA	NA	6.32	7.02	0.83	090
25300		A	Fusion of tendons at wrist	9.02	NA	NA	7.90	7.51	1.26	090
25301		A	Fusion of tendons at wrist	8.59	NA	NA	7.51	7.10	1.11	090
25310		A	Transplant forearm tendon	8.08	NA	NA	7.43	7.97	0.98	090
25312		A	Transplant forearm tendon	9.82	NA	NA	8.19	8.72	1.26	090
25315		A	Revise palsy hand tendon(s)	10.68	NA	NA	8.44	9.11	1.51	090
25316		A	Revise palsy hand tendon(s)	12.90	NA	NA	10.60	10.36	1.15	090
25320		A	Repair/revise wrist joint	12.75	NA	NA	11.98	10.98	1.60	090
25332		A	Revise wrist joint	11.74	NA	NA	9.26	8.63	1.56	090
25335		A	Realignment of hand	13.39	NA	NA	7.21	8.98	0.66	090
25337		A	Reconstruct ulna/radioulnar	11.73	NA	NA	10.55	9.88	1.44	090
25350		A	Revision of radius	9.09	NA	NA	7.75	8.42	1.15	090
25355		A	Revision of radius	10.53	NA	NA	8.47	9.11	1.49	090
25360		A	Revision of ulna	8.74	NA	NA	7.53	8.24	1.18	090
25365		A	Revise radius & ulna	12.91	NA	NA	9.82	10.19	1.83	090
25370		A	Revise radius or ulna	14.10	NA	NA	10.89	11.18	2.00	090
25375		A	Revise radius & ulna	13.55	NA	NA	7.27	9.96	0.67	090
25390		A	Shorten radius or ulna	10.70	NA	NA	8.64	9.16	1.35	090
25391		A	Lengthen radius or ulna	14.28	NA	NA	10.49	10.92	2.03	090
25392		A	Shorten radius & ulna	14.58	NA	NA	10.64	11.08	2.07	090
25393		A	Lengthen radius & ulna	16.56	NA	NA	11.61	12.02	2.35	090
25394		A	Repair carpal bone, shorten	10.85	NA	NA	8.59	7.96	1.53	090
25400		A	Repair radius or ulna	11.28	NA	NA	8.88	9.46	1.49	090
25405		A	Repair/graft radius or ulna	15.01	NA	NA	11.02	11.43	1.97	090
25415		A	Repair radius & ulna	13.80	NA	NA	10.68	11.07	1.96	090
25420		A	Repair/graft radius & ulna	17.04	NA	NA	12.06	12.51	2.42	090
25425		A	Repair/graft radius or ulna	13.72	NA	NA	10.21	11.65	1.95	090
25426		A	Repair/graft radius & ulna	16.45	NA	NA	11.55	10.61	2.34	090
25430		A	Vasc graft into carpal bone	9.71	NA	NA	8.93	7.77	0.86	090
25431		A	Repair nonunion carpal bone	10.89	NA	NA	8.68	7.93	1.54	090
25440		A	Repair/graft wrist bone	10.68	NA	NA	8.44	8.07	1.35	090
25441		A	Reconstruct wrist joint	13.29	NA	NA	10.81	9.60	1.18	090

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25442		A	Reconstruct wrist joint	11.12	NA	NA	9.21	8.48	0.99	090
25443		A	Reconstruct wrist joint	10.66	NA	NA	8.70	8.16	1.50	090
25444		A	Reconstruct wrist joint	11.42	NA	NA	6.48	7.82	0.57	090
25445		A	Reconstruct wrist joint	9.88	NA	NA	8.12	7.53	1.27	090
25446		A	Wrist replacement	17.30	NA	NA	12.29	11.33	2.12	090
25447		A	Repair wrist joint(s)	11.14	NA	NA	9.60	8.73	1.40	090
25449		A	Remove wrist joint implant	14.94	NA	NA	10.80	10.09	2.12	090
25450		A	Revision of wrist joint	8.06	NA	NA	6.42	6.37	1.13	090
25455		A	Revision of wrist joint	9.71	NA	NA	5.87	6.78	0.48	090
25490		A	Reinforce radius	9.73	NA	NA	7.31	8.24	0.89	090
25491		A	Reinforce ulna	10.15	NA	NA	8.19	8.86	1.43	090
25492		A	Reinforce radius and ulna	12.66	NA	NA	9.79	10.21	1.80	090
25500		A	Treat fracture of radius	2.60	3.99	3.58	3.48	3.04	0.32	090
25505		A	Treat fracture of radius	5.45	6.92	6.37	5.96	5.43	0.72	090
25515		A	Treat fracture of radius	8.80	NA	NA	7.83	7.23	1.19	090
25520		A	Treat fracture of radius	6.50	7.40	6.53	6.72	5.89	0.90	090
25525		A	Treat fracture of radius	10.55	NA	NA	8.89	8.54	1.45	090
25526		A	Treat fracture of radius	13.15	NA	NA	10.42	10.40	1.86	090
25530		A	Treat fracture of ulna	2.24	4.10	3.75	3.52	3.15	0.29	090
25535		A	Treat fracture of ulna	5.36	6.67	6.09	5.84	5.33	0.71	090
25545		A	Treat fracture of ulna	7.94	NA	NA	7.52	7.03	1.06	090
25560		A	Treat fracture radius & ulna	2.59	4.10	3.68	3.49	3.03	0.33	090
25565		A	Treat fracture radius & ulna	5.85	6.97	6.48	5.85	5.40	0.78	090
25574		A	Treat fracture radius & ulna	8.80	NA	NA	7.94	7.24	1.21	090
25575		A	Treat fracture radius/ulna	12.29	NA	NA	10.11	9.33	1.70	090
25600		A	Treat fracture radius/ulna	2.78	4.35	3.99	3.77	3.34	0.36	090
25605		A	Treat fracture radius/ulna	7.25	8.14	7.41	7.31	6.60	0.97	090
25606		A	Treat fx distal radial	8.31	NA	NA	8.05	7.67	1.13	090
25607		A	Treat fx rad extra-articul	9.56	NA	NA	8.71	7.83	1.28	090
25608		A	Treat fx rad intra-articul	11.07	NA	NA	9.49	8.53	1.48	090
25609		A	Treat fx radial 3+ frag	14.38	NA	NA	11.79	10.59	1.92	090
25622		A	Treat wrist bone fracture	2.79	4.63	4.20	4.00	3.52	0.36	090
25624		A	Treat wrist bone fracture	4.77	6.61	6.12	5.64	5.16	0.63	090
25628		A	Treat wrist bone fracture	9.67	NA	NA	8.32	7.66	1.23	090
25630		A	Treat wrist bone fracture	3.03	4.47	4.07	3.89	3.41	0.39	090
25635		A	Treat wrist bone fracture	4.61	6.47	5.76	5.55	4.69	0.63	090
25645		A	Treat wrist bone fracture	7.42	NA	NA	6.63	6.15	1.04	090
25650		A	Treat wrist bone fracture	3.23	4.57	4.19	4.11	3.63	0.41	090
25651		A	Pin ulnar styloid fracture	5.82	NA	NA	6.18	5.62	0.78	090

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25652		A	Treat fracture ulnar styloid	8.06	NA	NA	7.44	6.85	1.04	090
25660		A	Treat wrist dislocation	4.98	NA	NA	5.19	4.70	0.64	090
25670		A	Treat wrist dislocation	8.09	NA	NA	7.02	6.54	1.06	090
25671		A	Pin radioulnar dislocation	6.46	NA	NA	6.60	6.05	0.90	090
25675		A	Treat wrist dislocation	4.89	5.76	5.31	4.92	4.49	0.61	090
25676		A	Treat wrist dislocation	8.29	NA	NA	7.32	6.86	1.09	090
25680		A	Treat wrist fracture	6.23	NA	NA	5.46	4.86	0.75	090
25685		A	Treat wrist fracture	10.09	NA	NA	8.15	7.50	1.43	090
25690		A	Treat wrist dislocation	5.72	NA	NA	6.08	5.44	0.79	090
25695		A	Treat wrist dislocation	8.51	NA	NA	7.16	6.69	1.19	090
25800		A	Fusion of wrist joint	10.07	NA	NA	8.31	7.85	1.28	090
25805		A	Fusion/graft of wrist joint	11.73	NA	NA	9.23	8.87	1.66	090
25810		A	Fusion/graft of wrist joint	11.95	NA	NA	9.80	9.12	1.51	090
25820		A	Fusion of hand bones	7.64	NA	NA	7.69	7.16	0.97	090
25825		A	Fuse hand bones with graft	9.69	NA	NA	9.21	8.59	1.21	090
25830		A	Fusion, radioulnar jnt/ulna	10.88	NA	NA	12.60	12.07	1.53	090
25900		A	Amputation of forearm	9.61	NA	NA	8.01	8.35	1.29	090
25905		A	Amputation of forearm	9.59	NA	NA	7.79	8.07	1.35	090
25907		A	Amputation follow-up surgery	8.09	NA	NA	7.05	7.40	1.13	090
25909		A	Amputation follow-up surgery	9.31	NA	NA	7.65	7.99	1.31	090
25915		A	Amputation of forearm	17.52	NA	NA	6.52	11.04	2.23	090
25920		A	Amputate hand at wrist	9.03	NA	NA	8.17	7.55	1.27	090
25922		A	Amputate hand at wrist	7.65	NA	NA	5.23	5.97	0.38	090
25924		A	Amputation follow-up surgery	8.81	NA	NA	7.97	7.38	1.24	090
25927		A	Amputation of hand	9.09	NA	NA	10.77	9.97	1.27	090
25929		A	Amputation follow-up surgery	7.82	NA	NA	6.92	5.89	1.10	090
25931		A	Amputation follow-up surgery	8.04	NA	NA	8.56	8.97	1.22	090
25999		C	Forearm or wrist surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26010		A	Drainage of finger abscess	1.59	4.71	4.55	1.83	1.65	0.19	010
26011		A	Drainage of finger abscess	2.24	7.13	7.04	2.37	2.19	0.29	010
26020		A	Drain hand tendon sheath	5.08	NA	NA	5.67	5.22	0.66	090
26025		A	Drainage of palm bursa	5.08	NA	NA	5.44	4.94	0.65	090
26030		A	Drainage of palm bursa(s)	6.25	NA	NA	6.02	5.53	0.82	090
26034		A	Treat hand bone lesion	6.63	NA	NA	6.70	6.17	0.86	090
26035		A	Decompress fingers/hand	11.37	NA	NA	9.85	8.73	1.59	090
26037		A	Decompress fingers/hand	7.57	NA	NA	6.65	6.11	1.02	090
26040		A	Release palm contracture	3.46	NA	NA	4.28	3.93	0.40	090
26045		A	Release palm contracture	5.73	NA	NA	5.84	5.40	0.77	090
26055		A	Incise finger tendon sheath	3.11	10.32	10.46	4.51	4.10	0.39	090

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26060		A	Incision of finger tendon	2.91	NA	NA	3.66	3.40	0.39	090
26070		A	Explore/treat hand joint	3.81	NA	NA	3.83	3.43	0.46	090
26075		A	Explore/treat finger joint	3.91	NA	NA	4.14	3.74	0.48	090
26080		A	Explore/treat finger joint	4.47	NA	NA	5.15	4.74	0.56	090
26100		A	Biopsy hand joint lining	3.79	NA	NA	4.41	3.97	0.53	090
26105		A	Biopsy finger joint lining	3.83	NA	NA	4.43	4.06	0.53	090
26110		A	Biopsy finger joint lining	3.65	NA	NA	4.31	3.96	0.45	090
26111		A	Exc hand les sc > 1.5 cm	5.42	NA	NA	5.01	5.01	0.69	090
26113		A	Exc hand tum deep > 1.5 cm	7.13	NA	NA	6.61	6.61	0.89	090
26115		A	Exc hand les sc < 1.5 cm	3.96	8.07	10.11	4.36	4.46	0.51	090
26116		A	Exc hand tum deep < 1.5 cm	6.74	NA	NA	6.41	5.85	0.71	090
26117		A	Exc hand tum ra < 3 cm	10.13	NA	NA	8.60	7.16	1.13	090
26118		A	Exc hand tum ra > 3 cm	14.81	NA	NA	11.83	11.83	2.09	090
26121		A	Release palm contracture	7.73	NA	NA	7.16	6.62	0.99	090
26123		A	Release palm contracture	10.88	NA	NA	9.97	9.03	1.36	090
26125		A	Release palm contracture	4.60	NA	NA	2.41	2.23	0.59	ZZZ
26130		A	Remove wrist joint lining	5.59	NA	NA	5.80	5.30	0.74	090
26135		A	Revise finger joint, each	7.13	NA	NA	6.56	6.10	0.90	090
26140		A	Revise finger joint, each	6.34	NA	NA	6.20	5.75	0.80	090
26145		A	Tendon excision, palm/finger	6.49	NA	NA	6.24	5.77	0.83	090
26160		A	Remove tendon sheath lesion	3.57	10.27	10.08	4.66	4.24	0.46	090
26170		A	Removal of palm tendon, each	4.91	NA	NA	5.21	4.80	0.61	090
26180		A	Removal of finger tendon	5.35	NA	NA	5.72	5.27	0.65	090
26185		A	Remove finger bone	6.52	NA	NA	7.00	6.36	0.90	090
26200		A	Remove hand bone lesion	5.65	NA	NA	5.52	5.14	0.73	090
26205		A	Remove/graft bone lesion	7.93	NA	NA	6.94	6.51	1.11	090
26210		A	Removal of finger lesion	5.32	NA	NA	5.64	5.22	0.67	090
26215		A	Remove/graft finger lesion	7.27	NA	NA	6.62	6.10	1.02	090
26230		A	Partial removal of hand bone	6.47	NA	NA	5.95	5.56	0.80	090
26235		A	Partial removal, finger bone	6.33	NA	NA	6.00	5.54	0.78	090
26236		A	Partial removal, finger bone	5.46	NA	NA	5.53	5.10	0.69	090
26250		A	Extensive hand surgery	15.21	NA	NA	11.43	7.50	1.08	090
26260		A	Resect prox finger tumor	11.16	NA	NA	8.80	6.56	1.01	090
26262		A	Resect distal finger tumor	8.29	NA	NA	7.39	5.62	0.81	090
26320		A	Removal of implant from hand	4.10	NA	NA	4.51	4.16	0.50	090
26340		A	Manipulate finger w/anesth	2.80	NA	NA	5.36	4.91	0.35	090
26350		A	Repair finger/hand tendon	6.21	NA	NA	10.93	10.98	0.79	090
26352		A	Repair/graft hand tendon	7.87	NA	NA	11.76	11.63	1.10	090
26356		A	Repair finger/hand tendon	10.62	NA	NA	15.99	15.42	1.34	090

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26357		A	Repair finger/hand tendon	8.77	NA	NA	12.21	12.07	1.23	090
26358		A	Repair/graft hand tendon	9.36	NA	NA	12.77	12.69	1.31	090
26370		A	Repair finger/hand tendon	7.28	NA	NA	11.12	11.19	0.96	090
26372		A	Repair/graft hand tendon	9.01	NA	NA	12.32	12.34	1.26	090
26373		A	Repair finger/hand tendon	8.41	NA	NA	12.03	11.98	1.18	090
26390		A	Revise hand/finger tendon	9.43	NA	NA	10.84	10.51	1.32	090
26392		A	Repair/graft hand tendon	10.50	NA	NA	13.05	12.81	1.48	090
26410		A	Repair hand tendon	4.77	NA	NA	8.81	8.88	0.63	090
26412		A	Repair/graft hand tendon	6.48	NA	NA	10.04	10.05	0.81	090
26415		A	Excision, hand/finger tendon	8.51	NA	NA	8.88	8.85	0.83	090
26416		A	Graft hand or finger tendon	9.56	NA	NA	11.86	9.87	1.34	090
26418		A	Repair finger tendon	4.47	NA	NA	9.36	9.36	0.58	090
26420		A	Repair/graft finger tendon	6.94	NA	NA	10.36	10.23	0.97	090
26426		A	Repair finger/hand tendon	6.32	NA	NA	6.16	7.09	0.81	090
26428		A	Repair/graft finger tendon	7.40	NA	NA	10.80	10.67	1.03	090
26432		A	Repair finger tendon	4.16	NA	NA	7.86	7.82	0.53	090
26433		A	Repair finger tendon	4.70	NA	NA	8.08	8.10	0.61	090
26434		A	Repair/graft finger tendon	6.26	NA	NA	9.29	9.11	0.87	090
26437		A	Realignment of tendons	5.99	NA	NA	9.08	8.98	0.73	090
26440		A	Release palm/finger tendon	5.16	NA	NA	9.78	9.90	0.64	090
26442		A	Release palm & finger tendon	9.75	NA	NA	13.79	13.31	1.22	090
26445		A	Release hand/finger tendon	4.45	NA	NA	9.43	9.57	0.56	090
26449		A	Release forearm/hand tendon	8.59	NA	NA	8.79	9.51	1.06	090
26450		A	Incision of palm tendon	3.79	NA	NA	6.07	5.91	0.49	090
26455		A	Incision of finger tendon	3.76	NA	NA	6.00	5.86	0.49	090
26460		A	Incise hand/finger tendon	3.58	NA	NA	5.92	5.79	0.44	090
26471		A	Fusion of finger tendons	5.90	NA	NA	9.03	8.87	0.73	090
26474		A	Fusion of finger tendons	5.49	NA	NA	8.91	8.75	0.76	090
26476		A	Tendon lengthening	5.35	NA	NA	8.84	8.53	0.74	090
26477		A	Tendon shortening	5.32	NA	NA	8.75	8.62	0.71	090
26478		A	Lengthening of hand tendon	5.97	NA	NA	9.10	9.08	0.77	090
26479		A	Shortening of hand tendon	5.91	NA	NA	9.11	9.00	0.82	090
26480		A	Transplant hand tendon	6.90	NA	NA	11.35	11.29	0.86	090
26483		A	Transplant/graft hand tendon	8.48	NA	NA	11.83	11.88	1.11	090
26485		A	Transplant palm tendon	7.89	NA	NA	11.67	11.68	1.00	090
26489		A	Transplant/graft palm tendon	9.86	NA	NA	12.74	11.63	1.39	090
26490		A	Revise thumb tendon	8.60	NA	NA	10.39	10.27	1.20	090
26492		A	Tendon transfer with graft	9.84	NA	NA	11.53	11.21	1.39	090
26494		A	Hand tendon/muscle transfer	8.66	NA	NA	10.68	10.44	1.21	090

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26496		A	Revise thumb tendon	9.78	NA	NA	11.34	10.93	1.18	090
26497		A	Finger tendon transfer	9.76	NA	NA	11.22	10.94	1.37	090
26498		A	Finger tendon transfer	14.21	NA	NA	13.68	13.26	2.02	090
26499		A	Revision of finger	9.17	NA	NA	10.93	10.63	1.29	090
26500		A	Hand tendon reconstruction	6.13	NA	NA	9.04	8.92	0.81	090
26502		A	Hand tendon reconstruction	7.31	NA	NA	9.80	9.61	1.02	090
26508		A	Release thumb contracture	6.18	NA	NA	8.94	8.88	0.78	090
26510		A	Thumb tendon transfer	5.60	NA	NA	8.86	8.80	0.68	090
26516		A	Fusion of knuckle joint	7.32	NA	NA	9.76	9.56	0.92	090
26517		A	Fusion of knuckle joints	9.08	NA	NA	10.88	10.69	1.27	090
26518		A	Fusion of knuckle joints	9.27	NA	NA	10.98	10.74	1.30	090
26520		A	Release knuckle contracture	5.47	NA	NA	10.22	10.30	0.69	090
26525		A	Release finger contracture	5.50	NA	NA	10.22	10.32	0.68	090
26530		A	Revise knuckle joint	6.88	NA	NA	6.50	5.98	0.87	090
26531		A	Revise knuckle with implant	8.13	NA	NA	7.48	6.87	0.99	090
26535		A	Revise finger joint	5.41	NA	NA	5.03	4.38	0.59	090
26536		A	Revise/implant finger joint	6.56	NA	NA	10.75	9.86	0.79	090
26540		A	Repair hand joint	6.60	NA	NA	9.38	9.27	0.84	090
26541		A	Repair hand joint with graft	8.81	NA	NA	10.83	10.55	1.08	090
26542		A	Repair hand joint with graft	6.95	NA	NA	9.35	9.40	0.89	090
26545		A	Reconstruct finger joint	7.11	NA	NA	9.84	9.62	0.90	090
26546		A	Repair nonunion hand	10.83	NA	NA	13.23	12.83	1.30	090
26548		A	Reconstruct finger joint	8.22	NA	NA	10.30	10.13	1.06	090
26550		A	Construct thumb replacement	21.68	NA	NA	18.68	15.20	3.08	090
26551		A	Great toe-hand transfer	48.48	NA	NA	33.43	28.93	6.89	090
26553		A	Single transfer, toe-hand	48.17	NA	NA	23.96	21.88	2.42	090
26554		A	Double transfer, toe-hand	57.01	NA	NA	27.52	29.03	2.86	090
26555		A	Positional change of finger	17.08	NA	NA	17.31	16.08	2.42	090
26556		A	Toe joint transfer	49.75	NA	NA	13.67	19.80	2.85	090
26560		A	Repair of web finger	5.52	NA	NA	8.43	8.20	0.77	090
26561		A	Repair of web finger	11.10	NA	NA	9.88	10.43	1.71	090
26562		A	Repair of web finger	16.68	NA	NA	11.39	14.04	0.82	090
26565		A	Correct metacarpal flaw	6.91	NA	NA	9.56	9.38	0.97	090
26567		A	Correct finger deformity	6.99	NA	NA	9.60	9.43	0.88	090
26568		A	Lengthen metacarpal/finger	9.27	NA	NA	12.45	12.24	1.30	090
26580		A	Repair hand deformity	19.75	NA	NA	17.35	14.70	2.79	090
26587		A	Reconstruct extra finger	14.50	NA	NA	9.10	8.60	2.23	090
26590		A	Repair finger deformity	18.67	NA	NA	15.88	12.47	2.65	090
26591		A	Repair muscles of hand	3.38	NA	NA	6.95	7.14	0.43	090

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26593		A	Release muscles of hand	5.50	NA	NA	9.09	8.91	0.66	090
26596		A	Excision constricting tissue	9.14	NA	NA	9.44	8.55	1.28	090
26600		A	Treat metacarpal fracture	2.60	4.55	4.03	4.15	3.56	0.33	090
26605		A	Treat metacarpal fracture	3.03	4.82	4.43	4.16	3.76	0.39	090
26607		A	Treat metacarpal fracture	5.48	NA	NA	5.73	5.04	0.75	090
26608		A	Treat metacarpal fracture	5.55	NA	NA	6.23	5.82	0.73	090
26615		A	Treat metacarpal fracture	7.07	NA	NA	7.21	6.35	0.92	090
26641		A	Treat thumb dislocation	4.13	4.90	4.51	4.17	3.77	0.51	090
26645		A	Treat thumb fracture	4.58	5.85	5.18	5.04	4.41	0.63	090
26650		A	Treat thumb fracture	5.35	NA	NA	6.44	6.03	0.70	090
26665		A	Treat thumb fracture	7.94	NA	NA	7.68	6.92	1.03	090
26670		A	Treat hand dislocation	3.83	4.35	3.94	3.65	3.19	0.47	090
26675		A	Treat hand dislocation	4.83	6.25	5.55	5.40	4.74	0.67	090
26676		A	Pin hand dislocation	5.74	NA	NA	6.62	6.20	0.74	090
26685		A	Treat hand dislocation	7.07	NA	NA	7.20	6.50	0.98	090
26686		A	Treat hand dislocation	8.17	NA	NA	7.23	6.70	1.14	090
26700		A	Treat knuckle dislocation	3.83	4.01	3.60	3.57	3.11	0.47	090
26705		A	Treat knuckle dislocation	4.38	5.79	5.18	4.95	4.38	0.57	090
26706		A	Pin knuckle dislocation	5.31	NA	NA	5.62	5.07	0.67	090
26715		A	Treat knuckle dislocation	7.03	NA	NA	7.11	6.35	0.93	090
26720		A	Treat finger fracture, each	1.76	3.05	2.77	2.73	2.40	0.22	090
26725		A	Treat finger fracture, each	3.48	4.82	4.47	4.06	3.66	0.45	090
26727		A	Treat finger fracture, each	5.42	NA	NA	6.18	5.77	0.70	090
26735		A	Treat finger fracture, each	7.42	NA	NA	7.40	6.53	0.96	090
26740		A	Treat finger fracture, each	2.07	3.52	3.19	3.20	2.86	0.25	090
26742		A	Treat finger fracture, each	3.99	5.05	4.69	4.27	3.89	0.51	090
26746		A	Treat finger fracture, each	9.80	NA	NA	8.73	7.50	1.26	090
26750		A	Treat finger fracture, each	1.80	2.69	2.43	2.70	2.35	0.23	090
26755		A	Treat finger fracture, each	3.23	4.43	4.11	3.52	3.16	0.41	090
26756		A	Pin finger fracture, each	4.58	NA	NA	5.72	5.34	0.59	090
26765		A	Treat finger fracture, each	5.86	NA	NA	6.54	5.66	0.77	090
26770		A	Treat finger dislocation	3.15	3.55	3.19	3.10	2.67	0.38	090
26775		A	Treat finger dislocation	3.90	5.48	5.04	4.63	4.14	0.49	090
26776		A	Pin finger dislocation	4.99	NA	NA	5.90	5.53	0.65	090
26785		A	Treat finger dislocation	6.60	NA	NA	6.94	5.97	0.85	090
26820		A	Thumb fusion with graft	8.45	NA	NA	10.57	10.41	1.18	090
26841		A	Fusion of thumb	7.35	NA	NA	10.30	10.17	0.98	090
26842		A	Thumb fusion with graft	8.49	NA	NA	10.59	10.46	1.19	090
26843		A	Fusion of hand joint	7.78	NA	NA	10.03	9.84	1.09	090

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26844		A	Fusion/graft of hand joint	8.98	NA	NA	10.83	10.63	1.26	090
26850		A	Fusion of knuckle	7.14	NA	NA	9.72	9.58	0.88	090
26852		A	Fusion of knuckle with graft	8.71	NA	NA	10.75	10.47	1.04	090
26860		A	Fusion of finger joint	4.88	NA	NA	8.72	8.65	0.60	090
26861		A	Fusion of finger jnt, add-on	1.74	NA	NA	0.90	0.83	0.22	ZZZ
26862		A	Fusion/graft of finger joint	7.56	NA	NA	10.18	9.91	0.93	090
26863		A	Fuse/graft added joint	3.89	NA	NA	1.91	1.84	0.55	ZZZ
26910		A	Amputate metacarpal bone	7.79	NA	NA	9.65	9.36	1.06	090
26951		A	Amputation of finger/thumb	6.04	NA	NA	9.75	9.20	0.79	090
26952		A	Amputation of finger/thumb	6.48	NA	NA	9.16	9.08	0.85	090
26989		C	Hand/finger surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26990		A	Drainage of pelvis lesion	7.95	NA	NA	7.43	6.91	1.12	090
26991		A	Drainage of pelvis bursa	7.06	10.20	9.71	5.96	5.44	0.99	090
26992		A	Drainage of bone lesion	13.48	NA	NA	10.41	9.65	1.93	090
27000		A	Incision of hip tendon	5.74	NA	NA	5.04	4.90	0.76	090
27001		A	Incision of hip tendon	7.14	NA	NA	6.28	5.82	0.99	090
27003		A	Incision of hip tendon	7.81	NA	NA	6.92	6.30	1.09	090
27005		A	Incision of hip tendon	10.07	NA	NA	8.02	7.44	1.42	090
27006		A	Incision of hip tendons	10.11	NA	NA	8.19	7.62	1.41	090
27025		A	Incision of hip/thigh fascia	12.89	NA	NA	9.84	8.88	1.84	090
27027		A	Buttock fasciotomy	13.04	NA	NA	9.09	8.08	0.65	090
27030		A	Drainage of hip joint	13.65	NA	NA	9.78	9.12	1.93	090
27033		A	Exploration of hip joint	14.11	NA	NA	10.17	9.49	2.00	090
27035		A	Denervation of hip joint	17.37	NA	NA	12.00	9.79	2.47	090
27036		A	Excision of hip joint/muscle	14.38	NA	NA	10.71	9.93	2.00	090
27040		A	Biopsy of soft tissues	2.92	5.44	5.39	2.08	2.04	0.34	010
27041		A	Biopsy of soft tissues	10.18	NA	NA	6.61	6.42	1.29	090
27043		A	Exc hip pelvis les sc > 3 cm	6.88	NA	NA	4.80	4.80	1.01	090
27045		A	Exc hip/pelv tum deep > 5 cm	11.13	NA	NA	7.42	7.42	1.63	090
27047		A	Exc hip/pelvis les sc < 3 cm	4.94	6.57	7.05	4.12	4.57	1.12	090
27048		A	Exc hip/pelv tum deep < 5 cm	8.85	NA	NA	6.34	5.22	0.95	090
27049		A	Resect hip/pelv tum < 5 cm	21.55	NA	NA	12.40	9.56	2.22	090
27050		A	Biopsy of sacroiliac joint	4.74	NA	NA	5.13	4.03	0.66	090
27052		A	Biopsy of hip joint	7.42	NA	NA	6.85	6.14	1.03	090
27054		A	Removal of hip joint lining	9.21	NA	NA	7.82	7.20	1.29	090
27057		A	Buttock fasciotomy w/dbrdmt	14.91	NA	NA	10.39	8.98	0.74	090
27059		A	Resect hip/pelv tum > 5 cm	29.35	NA	NA	15.95	15.95	4.17	090
27060		A	Removal of ischial bursa	5.87	NA	NA	4.61	4.47	0.82	090
27062		A	Remove femur lesion/bursa	5.75	NA	NA	5.51	5.08	0.80	090

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27065		A	Removal of hip bone lesion	6.55	NA	NA	6.03	5.56	0.91	090
27066		A	Removal of hip bone lesion	11.20	NA	NA	9.00	8.30	1.59	090
27067		A	Remove/graft hip bone lesion	14.72	NA	NA	11.01	10.24	2.09	090
27070		A	Partial removal of hip bone	11.56	NA	NA	9.69	8.95	1.63	090
27071		A	Partial removal of hip bone	12.39	NA	NA	10.25	9.56	1.76	090
27075		A	Resect hip tumor	32.71	NA	NA	19.16	18.45	5.26	090
27076		A	Resect hip tum incl acetabul	40.21	NA	NA	22.86	16.14	3.46	090
27077		A	Resect hip tum w/innom bone	45.21	NA	NA	26.15	22.51	6.08	090
27078		A	Rsect hip tum incl femur	32.21	NA	NA	19.77	12.21	2.09	090
27080		A	Removal of tail bone	6.89	NA	NA	5.76	5.13	1.01	090
27086		A	Remove hip foreign body	1.92	4.08	4.02	1.75	1.67	0.22	010
27087		A	Remove hip foreign body	8.83	NA	NA	6.96	6.43	1.22	090
27090		A	Removal of hip prosthesis	11.69	NA	NA	8.99	8.36	1.65	090
27091		A	Removal of hip prosthesis	24.35	NA	NA	15.85	14.43	3.45	090
27093		A	Injection for hip x-ray	1.30	3.39	3.51	0.54	0.52	0.11	000
27095		A	Injection for hip x-ray	1.50	4.24	4.33	0.64	0.59	0.12	000
27096		A	Inject sacroiliac joint	1.40	3.43	3.16	0.55	0.41	0.09	000
27097		A	Revision of hip tendon	9.27	NA	NA	7.63	6.82	1.30	090
27098		A	Transfer tendon to pelvis	9.32	NA	NA	5.88	5.81	1.31	090
27100		A	Transfer of abdominal muscle	11.35	NA	NA	9.14	8.45	1.60	090
27105		A	Transfer of spinal muscle	12.04	NA	NA	9.48	8.81	1.71	090
27110		A	Transfer of iliopsoas muscle	13.77	NA	NA	10.33	9.38	1.96	090
27111		A	Transfer of iliopsoas muscle	12.60	NA	NA	9.75	8.27	1.79	090
27120		A	Reconstruction of hip socket	19.25	NA	NA	13.21	11.99	2.73	090
27122		A	Reconstruction of hip socket	16.09	NA	NA	11.44	10.62	2.27	090
27125		A	Partial hip replacement	16.64	NA	NA	11.72	10.73	2.35	090
27130		A	Total hip arthroplasty	21.79	NA	NA	14.45	13.26	3.08	090
27132		A	Total hip arthroplasty	25.69	NA	NA	16.51	15.25	3.63	090
27134		A	Revise hip joint replacement	30.28	NA	NA	18.13	16.88	4.30	090
27137		A	Revise hip joint replacement	22.70	NA	NA	14.42	13.38	3.22	090
27138		A	Revise hip joint replacement	23.70	NA	NA	14.91	13.83	3.36	090
27140		A	Transplant femur ridge	12.78	NA	NA	9.57	8.91	1.82	090
27146		A	Incision of hip bone	18.92	NA	NA	13.17	11.84	2.68	090
27147		A	Revision of hip bone	22.07	NA	NA	14.71	13.54	3.13	090
27151		A	Incision of hip bones	24.12	NA	NA	15.72	13.24	3.42	090
27156		A	Revision of hip bones	26.23	NA	NA	16.75	15.28	3.72	090
27158		A	Revision of pelvis	21.04	NA	NA	14.01	12.55	2.99	090
27161		A	Incision of neck of femur	17.89	NA	NA	12.48	11.63	2.53	090
27165		A	Incision/fixation of femur	20.29	NA	NA	14.15	12.95	2.86	090

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27170		A	Repair/graft femur head/neck	17.61	NA	NA	11.92	11.01	2.49	090
27175		A	Treat slipped epiphysis	9.38	NA	NA	7.20	6.63	1.32	090
27176		A	Treat slipped epiphysis	12.92	NA	NA	9.91	9.10	1.84	090
27177		A	Treat slipped epiphysis	16.09	NA	NA	11.68	10.78	2.28	090
27178		A	Treat slipped epiphysis	12.92	NA	NA	9.91	8.99	1.84	090
27179		A	Revise head/neck of femur	13.97	NA	NA	10.33	9.54	1.98	090
27181		A	Treat slipped epiphysis	16.18	NA	NA	11.82	10.74	2.29	090
27185		A	Revision of femur epiphysis	9.79	NA	NA	5.71	6.01	0.48	090
27187		A	Reinforce hip bones	14.23	NA	NA	10.53	9.81	2.02	090
27193		A	Treat pelvic ring fracture	6.09	5.57	5.10	5.72	5.21	0.84	090
27194		A	Treat pelvic ring fracture	10.20	NA	NA	7.13	6.90	1.19	090
27200		A	Treat tail bone fracture	1.92	2.51	2.24	2.68	2.35	0.25	090
27202		A	Treat tail bone fracture	7.31	NA	NA	5.90	7.55	1.03	090
27215		I	Treat pelvic fracture(s)	10.45	NA	NA	5.51	6.52	1.49	090
27216		I	Treat pelvic ring fracture	15.73	NA	NA	7.96	9.29	2.22	090
27217		I	Treat pelvic ring fracture	14.65	NA	NA	7.57	9.02	2.08	090
27218		I	Treat pelvic ring fracture	20.93	NA	NA	9.86	11.41	3.06	090
27220		A	Treat hip socket fracture	6.83	6.32	5.78	6.21	5.68	0.95	090
27222		A	Treat hip socket fracture	14.11	NA	NA	10.21	9.53	1.99	090
27226		A	Treat hip wall fracture	15.57	NA	NA	10.92	9.63	2.21	090
27227		A	Treat hip fracture(s)	25.41	NA	NA	16.32	15.11	3.59	090
27228		A	Treat hip fracture(s)	29.33	NA	NA	18.25	16.99	4.17	090
27230		A	Treat thigh fracture	5.81	5.95	5.45	5.87	5.31	0.80	090
27232		A	Treat thigh fracture	11.72	NA	NA	7.35	6.88	1.62	090
27235		A	Treat thigh fracture	13.00	NA	NA	9.65	9.00	1.84	090
27236		A	Treat thigh fracture	17.61	NA	NA	12.37	11.30	2.49	090
27238		A	Treat thigh fracture	5.75	NA	NA	5.63	5.14	0.80	090
27240		A	Treat thigh fracture	13.81	NA	NA	10.11	9.30	1.93	090
27244		A	Treat thigh fracture	18.18	NA	NA	12.64	11.56	2.57	090
27245		A	Treat thigh fracture	18.18	NA	NA	12.67	12.05	2.57	090
27246		A	Treat thigh fracture	4.83	4.68	4.32	4.72	4.35	0.67	090
27248		A	Treat thigh fracture	10.78	NA	NA	7.81	7.36	1.52	090
27250		A	Treat hip dislocation	3.82	NA	NA	0.81	1.52	0.48	000
27252		A	Treat hip dislocation	11.03	NA	NA	7.89	7.25	1.53	090
27253		A	Treat hip dislocation	13.58	NA	NA	9.93	9.25	1.93	090
27254		A	Treat hip dislocation	18.94	NA	NA	12.72	11.80	2.68	090
27256		A	Treat hip dislocation	4.28	2.93	2.80	1.74	1.65	0.54	010
27257		A	Treat hip dislocation	5.38	NA	NA	2.93	2.74	0.69	010
27258		A	Treat hip dislocation	16.18	NA	NA	11.51	10.61	2.30	090

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27259		A	Treat hip dislocation	23.26	NA	NA	15.57	14.32	3.29	090
27265		A	Treat hip dislocation	5.24	NA	NA	4.51	4.26	0.66	090
27266		A	Treat hip dislocation	7.78	NA	NA	6.62	6.13	1.08	090
27267		A	Cltx thigh fx	5.50	NA	NA	5.40	4.64	0.76	090
27268		A	Cltx thigh fx w/mnpj	7.12	NA	NA	6.20	5.33	0.99	090
27269		A	Optx thigh fx	18.89	NA	NA	12.30	10.67	2.66	090
27275		A	Manipulation of hip joint	2.32	NA	NA	2.06	1.98	0.28	010
27280		A	Fusion of sacroiliac joint	14.64	NA	NA	11.00	10.13	2.17	090
27282		A	Fusion of pubic bones	11.85	NA	NA	9.38	7.92	1.68	090
27284		A	Fusion of hip joint	25.06	NA	NA	15.54	12.89	3.56	090
27286		A	Fusion of hip joint	25.17	NA	NA	16.23	15.13	3.57	090
27290		A	Amputation of leg at hip	24.55	NA	NA	16.10	13.96	3.48	090
27295		A	Amputation of leg at hip	19.66	NA	NA	11.86	11.01	2.90	090
27299		C	Pelvis/hip joint surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27301		A	Drain thigh/knee lesion	6.78	9.61	9.09	5.63	5.15	0.97	090
27303		A	Drainage of bone lesion	8.63	NA	NA	7.27	6.72	1.21	090
27305		A	Incise thigh tendon & fascia	6.18	NA	NA	5.65	5.10	0.87	090
27306		A	Incision of thigh tendon	4.74	NA	NA	4.91	4.40	0.66	090
27307		A	Incision of thigh tendons	6.06	NA	NA	5.77	5.17	0.85	090
27310		A	Exploration of knee joint	10.00	NA	NA	8.19	7.53	1.41	090
27323		A	Biopsy, thigh soft tissues	2.33	4.38	4.17	2.15	2.03	0.30	010
27324		A	Biopsy, thigh soft tissues	5.04	NA	NA	4.58	4.19	0.74	090
27325		A	Neurectomy, hamstring	7.20	NA	NA	6.56	5.66	1.01	090
27326		A	Neurectomy, popliteal	6.47	NA	NA	6.20	5.37	0.90	090
27327		A	Exc thigh/knee les sc < 3 cm	3.96	7.19	6.42	3.83	3.76	0.67	090
27328		A	Exc thigh/knee tum deep <5cm	8.85	NA	NA	6.52	4.87	0.83	090
27329		A	Resect thigh/knee tum < 5 cm	15.72	NA	NA	10.37	9.38	2.30	090
27330		A	Biopsy, knee joint lining	5.11	NA	NA	4.79	4.48	0.68	090
27331		A	Explore/treat knee joint	6.02	NA	NA	5.74	5.32	0.84	090
27332		A	Removal of knee cartilage	8.46	NA	NA	7.44	6.89	1.18	090
27333		A	Removal of knee cartilage	7.55	NA	NA	6.91	6.39	1.06	090
27334		A	Remove knee joint lining	9.19	NA	NA	7.79	7.16	1.29	090
27335		A	Remove knee joint lining	10.55	NA	NA	8.49	7.87	1.49	090
27337		A	Exc thigh/knee les sc > 3 cm	5.91	NA	NA	4.55	4.55	0.86	090
27339		A	Exc thigh/knee tum deep >5cm	11.13	NA	NA	7.63	7.63	1.63	090
27340		A	Removal of kneecap bursa	4.32	NA	NA	4.81	4.44	0.60	090
27345		A	Removal of knee cyst	6.09	NA	NA	5.88	5.44	0.85	090
27347		A	Remove knee cyst	6.73	NA	NA	6.33	5.76	0.93	090
27350		A	Removal of kneecap	8.66	NA	NA	7.54	6.98	1.21	090

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27355		A	Remove femur lesion	8.00	NA	NA	6.96	6.47	1.12	090
27356		A	Remove femur lesion/graft	10.09	NA	NA	8.25	7.63	1.43	090
27357		A	Remove femur lesion/graft	11.16	NA	NA	9.03	8.40	1.58	090
27358		A	Remove femur lesion/fixation	4.73	NA	NA	2.32	2.22	0.67	ZZZ
27360		A	Partial removal, leg bone(s)	11.46	NA	NA	9.68	9.01	1.63	090
27364		A	Resect thigh/knee tum >5 cm	24.49	NA	NA	14.54	14.54	3.56	090
27365		A	Resect femur/knee tumor	32.21	NA	NA	19.78	13.45	2.57	090
27370		A	Injection for knee x-ray	0.96	3.26	3.22	0.43	0.38	0.09	000
27372		A	Removal of foreign body	5.21	9.63	9.14	4.86	4.50	0.73	090
27380		A	Repair of kneecap tendon	7.45	NA	NA	7.24	6.77	1.04	090
27381		A	Repair/graft kneecap tendon	10.76	NA	NA	9.11	8.51	1.52	090
27385		A	Repair of thigh muscle	8.11	NA	NA	7.57	7.08	1.13	090
27386		A	Repair/graft of thigh muscle	11.13	NA	NA	9.53	8.88	1.57	090
27390		A	Incision of thigh tendon	5.53	NA	NA	5.51	5.05	0.77	090
27391		A	Incision of thigh tendons	7.49	NA	NA	6.75	6.25	1.05	090
27392		A	Incision of thigh tendons	9.63	NA	NA	8.02	7.28	1.35	090
27393		A	Lengthening of thigh tendon	6.59	NA	NA	6.01	5.57	0.92	090
27394		A	Lengthening of thigh tendons	8.79	NA	NA	7.45	6.89	1.22	090
27395		A	Lengthening of thigh tendons	12.24	NA	NA	9.58	8.92	1.74	090
27396		A	Transplant of thigh tendon	8.15	NA	NA	7.08	6.60	1.14	090
27397		A	Transplants of thigh tendons	12.66	NA	NA	10.10	9.25	1.79	090
27400		A	Revise thigh muscles/tendons	9.33	NA	NA	7.87	7.25	1.31	090
27403		A	Repair of knee cartilage	8.62	NA	NA	7.31	6.80	1.20	090
27405		A	Repair of knee ligament	9.08	NA	NA	7.73	7.18	1.27	090
27407		A	Repair of knee ligament	10.85	NA	NA	8.80	7.80	1.53	090
27409		A	Repair of knee ligaments	13.71	NA	NA	10.30	9.55	1.95	090
27412		A	Autochondrocyte implant knee	24.74	NA	NA	16.65	15.24	3.50	090
27415		A	Osteochondral knee allograft	20.00	NA	NA	14.30	13.05	2.83	090
27416		A	Osteochondral knee autograft	14.16	NA	NA	10.27	9.22	2.01	090
27418		A	Repair degenerated kneecap	11.60	NA	NA	9.11	8.51	1.63	090
27420		A	Revision of unstable kneecap	10.26	NA	NA	8.31	7.73	1.44	090
27422		A	Revision of unstable kneecap	10.21	NA	NA	8.32	7.72	1.44	090
27424		A	Revision/removal of kneecap	10.24	NA	NA	8.32	7.73	1.45	090
27425		A	Lat retinacular release open	5.39	NA	NA	5.62	5.22	0.75	090
27427		A	Reconstruction, knee	9.79	NA	NA	8.12	7.50	1.37	090
27428		A	Reconstruction, knee	15.58	NA	NA	12.15	11.18	2.20	090
27429		A	Reconstruction, knee	17.54	NA	NA	13.70	12.50	2.47	090
27430		A	Revision of thigh muscles	10.16	NA	NA	8.28	7.66	1.43	090
27435		A	Incision of knee joint	10.88	NA	NA	9.27	8.45	1.53	090

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27437		A	Revise kneecap	8.93	NA	NA	7.45	6.93	1.25	090
27438		A	Revise kneecap with implant	11.89	NA	NA	9.12	8.40	1.69	090
27440		A	Revision of knee joint	11.09	NA	NA	8.72	7.59	1.57	090
27441		A	Revision of knee joint	11.54	NA	NA	8.94	7.74	1.63	090
27442		A	Revision of knee joint	12.37	NA	NA	9.39	8.60	1.76	090
27443		A	Revision of knee joint	11.41	NA	NA	8.88	8.24	1.61	090
27445		A	Revision of knee joint	18.66	NA	NA	12.79	11.83	2.65	090
27446		A	Revision of knee joint	16.38	NA	NA	11.35	10.58	2.32	090
27447		A	Total knee arthroplasty	23.25	NA	NA	15.45	14.25	3.29	090
27448		A	Incision of thigh	11.60	NA	NA	8.76	8.16	1.65	090
27450		A	Incision of thigh	14.61	NA	NA	10.78	10.02	2.08	090
27454		A	Realignment of thigh bone	19.17	NA	NA	13.29	11.99	2.71	090
27455		A	Realignment of knee	13.36	NA	NA	10.08	9.38	1.90	090
27457		A	Realignment of knee	14.03	NA	NA	9.98	9.33	2.00	090
27465		A	Shortening of thigh bone	18.60	NA	NA	12.71	11.34	2.64	090
27466		A	Lengthening of thigh bone	17.28	NA	NA	12.39	11.41	2.45	090
27468		A	Shorten/lengthen thighs	19.97	NA	NA	13.58	12.41	2.83	090
27470		A	Repair of thigh	17.14	NA	NA	12.36	11.45	2.42	090
27472		A	Repair/graft of thigh	18.72	NA	NA	12.98	12.08	2.66	090
27475		A	Surgery to stop leg growth	8.93	NA	NA	7.46	6.93	1.25	090
27477		A	Surgery to stop leg growth	10.14	NA	NA	8.05	7.48	1.43	090
27479		A	Surgery to stop leg growth	13.16	NA	NA	7.00	8.41	0.65	090
27485		A	Surgery to stop leg growth	9.13	NA	NA	7.49	6.99	1.28	090
27486		A	Revise/replace knee joint	21.12	NA	NA	14.26	13.16	2.99	090
27487		A	Revise/replace knee joint	27.11	NA	NA	17.23	15.95	3.83	090
27488		A	Removal of knee prosthesis	17.60	NA	NA	12.52	11.52	2.49	090
27495		A	Reinforce thigh	16.54	NA	NA	11.70	10.88	2.35	090
27496		A	Decompression of thigh/knee	6.78	NA	NA	6.62	5.59	0.95	090
27497		A	Decompression of thigh/knee	7.79	NA	NA	6.62	5.54	1.09	090
27498		A	Decompression of thigh/knee	8.66	NA	NA	7.54	6.02	1.21	090
27499		A	Decompression of thigh/knee	9.43	NA	NA	7.92	6.64	1.32	090
27500		A	Treatment of thigh fracture	6.30	6.51	5.96	5.61	5.08	0.87	090
27501		A	Treatment of thigh fracture	6.45	6.01	5.57	5.91	5.41	0.90	090
27502		A	Treatment of thigh fracture	11.36	NA	NA	8.19	7.62	1.57	090
27503		A	Treatment of thigh fracture	11.27	NA	NA	8.72	8.07	1.58	090
27506		A	Treatment of thigh fracture	19.65	NA	NA	13.87	12.74	2.77	090
27507		A	Treatment of thigh fracture	14.48	NA	NA	9.92	9.26	2.06	090
27508		A	Treatment of thigh fracture	6.20	6.78	6.24	6.06	5.52	0.85	090
27509		A	Treatment of thigh fracture	8.14	NA	NA	7.83	7.34	1.14	090

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27510		A	Treatment of thigh fracture	9.80	NA	NA	7.49	7.01	1.34	090
27511		A	Treatment of thigh fracture	15.11	NA	NA	9.92	9.52	2.14	090
27513		A	Treatment of thigh fracture	19.25	NA	NA	11.95	11.56	2.73	090
27514		A	Treatment of thigh fracture	14.60	NA	NA	9.66	9.74	2.07	090
27516		A	Treat thigh fx growth plate	5.59	6.85	6.20	6.13	5.51	0.77	090
27517		A	Treat thigh fx growth plate	9.12	NA	NA	7.86	7.26	1.28	090
27519		A	Treat thigh fx growth plate	13.25	NA	NA	9.01	8.93	1.88	090
27520		A	Treat kneecap fracture	3.04	4.84	4.44	4.18	3.74	0.41	090
27524		A	Treat kneecap fracture	10.37	NA	NA	8.38	7.80	1.46	090
27530		A	Treat knee fracture	4.09	5.69	5.23	5.06	4.58	0.56	090
27532		A	Treat knee fracture	7.55	7.65	7.08	6.77	6.25	1.05	090
27535		A	Treat knee fracture	13.41	NA	NA	9.09	8.69	1.90	090
27536		A	Treat knee fracture	17.39	NA	NA	12.43	11.45	2.45	090
27538		A	Treat knee fracture(s)	5.09	6.47	5.99	5.78	5.29	0.69	090
27540		A	Treat knee fracture	11.30	NA	NA	8.96	8.50	1.59	090
27550		A	Treat knee dislocation	5.98	6.22	5.78	5.39	4.96	0.77	090
27552		A	Treat knee dislocation	8.18	NA	NA	7.33	6.76	1.14	090
27556		A	Treat knee dislocation	13.00	NA	NA	8.89	8.82	1.85	090
27557		A	Treat knee dislocation	15.90	NA	NA	10.31	10.20	2.26	090
27558		A	Treat knee dislocation	18.39	NA	NA	11.53	11.14	2.61	090
27560		A	Treat kneecap dislocation	3.99	5.31	4.80	4.69	4.04	0.55	090
27562		A	Treat kneecap dislocation	5.98	NA	NA	5.93	5.21	0.83	090
27566		A	Treat kneecap dislocation	12.71	NA	NA	9.53	8.86	1.81	090
27570		A	Fixation of knee joint	1.79	NA	NA	1.92	1.77	0.25	010
27580		A	Fusion of knee	21.10	NA	NA	14.97	13.91	2.98	090
27590		A	Amputate leg at thigh	13.47	NA	NA	7.33	6.68	2.12	090
27591		A	Amputate leg at thigh	13.94	NA	NA	8.73	8.25	2.09	090
27592		A	Amputate leg at thigh	10.98	NA	NA	6.55	6.13	1.71	090
27594		A	Amputation follow-up surgery	7.29	NA	NA	5.64	5.19	1.10	090
27596		A	Amputation follow-up surgery	11.29	NA	NA	7.19	6.65	1.73	090
27598		A	Amputate lower leg at knee	11.22	NA	NA	7.60	7.00	1.69	090
27599		C	Leg surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27600		A	Decompression of lower leg	6.03	NA	NA	4.44	4.26	0.90	090
27601		A	Decompression of lower leg	6.05	NA	NA	5.05	4.74	0.90	090
27602		A	Decompression of lower leg	7.82	NA	NA	4.99	4.75	1.24	090
27603		A	Drain lower leg lesion	5.23	8.13	7.50	4.65	4.23	0.71	090
27604		A	Drain lower leg bursa	4.59	7.32	6.60	3.95	3.67	0.56	090
27605		A	Incision of achilles tendon	2.92	5.70	5.83	1.91	1.94	0.24	010
27606		A	Incision of achilles tendon	4.18	NA	NA	3.07	2.95	0.52	010

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
27607		A	Treat lower leg bone lesion	8.62	NA	NA	6.79	6.29	1.12	090
27610		A	Explore/treat ankle joint	9.13	NA	NA	7.28	6.78	1.17	090
27612		A	Exploration of ankle joint	8.15	NA	NA	6.04	5.77	0.82	090
27613		A	Biopsy lower leg soft tissue	2.22	4.08	3.90	1.95	1.88	0.23	010
27614		A	Biopsy lower leg soft tissue	5.80	8.68	7.89	4.52	4.23	0.73	090
27615		A	Resect leg/ankle tum < 5 cm	15.72	NA	NA	10.32	8.67	1.87	090
27616		A	Resect leg/ankle tum > 5 cm	19.63	NA	NA	12.32	12.32	2.81	090
27618		A	Exc leg/ankle tum < 3 cm	3.96	7.04	6.62	3.76	3.93	0.70	090
27619		A	Exc leg/ankle tum deep <5 cm	6.91	NA	NA	5.29	5.51	1.08	090
27620		A	Explore/treat ankle joint	6.15	NA	NA	5.42	5.08	0.74	090
27625		A	Remove ankle joint lining	8.49	NA	NA	6.13	5.91	0.91	090
27626		A	Remove ankle joint lining	9.10	NA	NA	6.87	6.44	1.09	090
27630		A	Removal of tendon lesion	4.94	8.92	8.17	4.31	4.10	0.56	090
27632		A	Exc leg/ankle les sc > 3 cm	5.91	NA	NA	4.47	4.47	0.80	090
27634		A	Exc leg/ankle tum deep >5 cm	10.13	NA	NA	6.81	6.81	1.28	090
27635		A	Remove lower leg bone lesion	8.03	NA	NA	6.76	6.34	1.06	090
27637		A	Remove/graft leg bone lesion	10.31	NA	NA	8.64	7.95	1.45	090
27638		A	Remove/graft leg bone lesion	10.99	NA	NA	8.45	7.88	1.55	090
27640		A	Partial removal of tibia	12.24	NA	NA	8.86	8.64	1.58	090
27641		A	Partial removal of fibula	9.84	NA	NA	7.18	6.95	1.20	090
27645		A	Resect tibia tumor	27.21	NA	NA	17.41	12.04	2.12	090
27646		A	Resect fibula tumor	23.21	NA	NA	15.45	10.59	1.90	090
27647		A	Resect talus/calcaneus tum	20.26	NA	NA	8.40	7.18	0.93	090
27648		A	Injection for ankle x-ray	0.96	3.15	3.08	0.41	0.37	0.09	000
27650		A	Repair achilles tendon	9.21	NA	NA	7.70	7.22	1.06	090
27652		A	Repair/graft achilles tendon	10.78	NA	NA	6.99	7.03	1.07	090
27654		A	Repair of achilles tendon	10.53	NA	NA	7.54	7.15	1.07	090
27656		A	Repair leg fascia defect	4.71	10.63	8.86	5.05	4.10	0.66	090
27658		A	Repair of leg tendon, each	5.12	NA	NA	4.50	4.24	0.56	090
27659		A	Repair of leg tendon, each	7.10	NA	NA	5.13	5.06	0.70	090
27664		A	Repair of leg tendon, each	4.73	NA	NA	4.42	4.19	0.54	090
27665		A	Repair of leg tendon, each	5.57	NA	NA	4.99	4.66	0.63	090
27675		A	Repair lower leg tendons	7.35	NA	NA	5.20	5.06	0.72	090
27676		A	Repair lower leg tendons	8.73	NA	NA	6.64	6.35	1.22	090
27680		A	Release of lower leg tendon	5.88	NA	NA	4.92	4.67	0.69	090
27681		A	Release of lower leg tendons	7.05	NA	NA	6.45	5.67	0.99	090
27685		A	Revision of lower leg tendon	6.69	9.91	8.86	5.18	4.99	0.65	090
27686		A	Revise lower leg tendons	7.75	NA	NA	6.12	5.91	0.93	090
27687		A	Revision of calf tendon	6.41	NA	NA	5.21	4.91	0.70	090

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27690		A	Revise lower leg tendon	9.17	NA	NA	7.07	6.54	0.94	090
27691		A	Revise lower leg tendon	10.49	NA	NA	8.58	7.89	1.29	090
27692		A	Revise additional leg tendon	1.87	NA	NA	0.86	0.82	0.24	ZZZ
27695		A	Repair of ankle ligament	6.70	NA	NA	5.61	5.35	0.76	090
27696		A	Repair of ankle ligaments	8.58	NA	NA	5.64	5.64	0.82	090
27698		A	Repair of ankle ligament	9.61	NA	NA	6.77	6.44	1.07	090
27700		A	Revision of ankle joint	9.66	NA	NA	5.86	5.57	0.85	090
27702		A	Reconstruct ankle joint	14.42	NA	NA	10.18	9.69	1.91	090
27703		A	Reconstruction, ankle joint	16.94	NA	NA	11.75	10.99	2.29	090
27704		A	Removal of ankle implant	7.81	NA	NA	6.60	6.04	1.01	090
27705		A	Incision of tibia	10.86	NA	NA	8.30	7.73	1.45	090
27707		A	Incision of fibula	4.78	NA	NA	5.27	4.87	0.64	090
27709		A	Incision of tibia & fibula	17.48	NA	NA	11.92	10.44	2.41	090
27712		A	Realignment of lower leg	15.87	NA	NA	11.68	10.76	2.25	090
27715		A	Revision of lower leg	15.50	NA	NA	11.18	10.37	2.20	090
27720		A	Repair of tibia	12.36	NA	NA	9.58	8.93	1.73	090
27722		A	Repair/graft of tibia	12.45	NA	NA	9.68	8.84	1.77	090
27724		A	Repair/graft of tibia	19.31	NA	NA	12.56	11.73	2.73	090
27725		A	Repair of lower leg	17.41	NA	NA	12.99	11.88	2.46	090
27726		A	Repair fibula nonunion	14.34	NA	NA	10.08	8.56	2.01	090
27727		A	Repair of lower leg	14.84	NA	NA	10.98	9.05	2.11	090
27730		A	Repair of tibia epiphysis	7.70	NA	NA	6.80	6.28	1.08	090
27732		A	Repair of fibula epiphysis	5.46	NA	NA	5.56	4.55	0.76	090
27734		A	Repair lower leg epiphyses	8.83	NA	NA	5.28	5.44	0.44	090
27740		A	Repair of leg epiphyses	9.61	NA	NA	7.95	6.65	1.35	090
27742		A	Repair of leg epiphyses	10.63	NA	NA	8.69	6.65	1.50	090
27745		A	Reinforce tibia	10.49	NA	NA	8.40	7.79	1.48	090
27750		A	Treatment of tibia fracture	3.37	5.10	4.68	4.44	4.00	0.45	090
27752		A	Treatment of tibia fracture	6.27	7.01	6.49	6.05	5.59	0.86	090
27756		A	Treatment of tibia fracture	7.45	NA	NA	6.84	6.31	1.03	090
27758		A	Treatment of tibia fracture	12.54	NA	NA	9.71	8.97	1.77	090
27759		A	Treatment of tibia fracture	14.45	NA	NA	10.53	9.81	2.04	090
27760		A	Cltx medial ankle fx	3.21	5.01	4.59	4.32	3.87	0.40	090
27762		A	Cltx med ankle fx w/mnpj	5.47	6.39	5.99	5.45	5.09	0.71	090
27766		A	Optx medial ankle fx	7.89	NA	NA	7.30	6.81	1.06	090
27767		A	Cltx post ankle fx	2.64	4.30	3.73	4.34	3.76	0.34	090
27768		A	Cltx post ankle fx w/mnpj	5.14	NA	NA	5.67	4.80	0.71	090
27769		A	Optx post ankle fx	10.14	NA	NA	8.17	6.91	1.43	090
27780		A	Treatment of fibula fracture	2.83	4.62	4.19	3.98	3.53	0.37	090

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27781		A	Treatment of fibula fracture	4.59	5.90	5.40	5.19	4.70	0.62	090
27784		A	Treatment of fibula fracture	9.67	NA	NA	8.22	7.34	1.33	090
27786		A	Treatment of ankle fracture	3.02	4.77	4.37	4.06	3.63	0.39	090
27788		A	Treatment of ankle fracture	4.64	5.79	5.39	4.95	4.58	0.60	090
27792		A	Treatment of ankle fracture	9.71	NA	NA	8.13	7.39	1.30	090
27808		A	Treatment of ankle fracture	3.03	5.14	4.72	4.35	3.93	0.39	090
27810		A	Treatment of ankle fracture	5.32	6.30	5.90	5.33	4.97	0.70	090
27814		A	Treatment of ankle fracture	10.62	NA	NA	8.72	8.12	1.47	090
27816		A	Treatment of ankle fracture	3.07	4.73	4.28	3.97	3.54	0.39	090
27818		A	Treatment of ankle fracture	5.69	6.24	5.86	5.12	4.81	0.74	090
27822		A	Treatment of ankle fracture	11.21	NA	NA	9.83	9.35	1.54	090
27823		A	Treatment of ankle fracture	13.16	NA	NA	10.77	10.19	1.82	090
27824		A	Treat lower leg fracture	3.31	4.38	4.03	4.17	3.77	0.43	090
27825		A	Treat lower leg fracture	6.69	6.88	6.38	5.71	5.28	0.91	090
27826		A	Treat lower leg fracture	11.10	NA	NA	9.76	8.98	1.52	090
27827		A	Treat lower leg fracture	14.79	NA	NA	12.23	11.54	2.06	090
27828		A	Treat lower leg fracture	18.43	NA	NA	14.06	13.10	2.58	090
27829		A	Treat lower leg joint	8.80	NA	NA	8.34	7.49	1.20	090
27830		A	Treat lower leg dislocation	3.96	5.34	4.64	4.73	4.08	0.55	090
27831		A	Treat lower leg dislocation	4.73	NA	NA	5.10	4.49	0.66	090
27832		A	Treat lower leg dislocation	10.17	NA	NA	8.58	7.41	1.43	090
27840		A	Treat ankle dislocation	4.77	NA	NA	4.20	3.82	0.59	090
27842		A	Treat ankle dislocation	6.46	NA	NA	5.76	5.27	0.86	090
27846		A	Treat ankle dislocation	10.28	NA	NA	8.13	7.60	1.40	090
27848		A	Treat ankle dislocation	11.68	NA	NA	8.91	8.47	1.61	090
27860		A	Fixation of ankle joint	2.39	NA	NA	1.98	1.92	0.29	010
27870		A	Fusion of ankle joint, open	15.41	NA	NA	10.87	10.15	2.02	090
27871		A	Fusion of tibiofibular joint	9.54	NA	NA	7.84	7.26	1.32	090
27880		A	Amputation of lower leg	15.37	NA	NA	8.20	7.41	2.39	090
27881		A	Amputation of lower leg	13.47	NA	NA	8.84	8.29	2.02	090
27882		A	Amputation of lower leg	9.79	NA	NA	5.82	5.57	1.53	090
27884		A	Amputation follow-up surgery	8.76	NA	NA	6.01	5.59	1.33	090
27886		A	Amputation follow-up surgery	10.02	NA	NA	6.87	6.36	1.52	090
27888		A	Amputation of foot at ankle	10.37	NA	NA	7.15	6.85	1.39	090
27889		A	Amputation of foot at ankle	10.86	NA	NA	5.96	5.88	1.73	090
27892		A	Decompression of leg	7.94	NA	NA	6.01	5.44	1.17	090
27893		A	Decompression of leg	7.90	NA	NA	5.88	5.57	1.20	090
27894		A	Decompression of leg	12.67	NA	NA	8.83	8.15	1.91	090
27899		C	Leg/ankle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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28001		A	Drainage of bursa of foot	2.78	4.20	3.86	1.65	1.70	0.16	010
28002		A	Treatment of foot infection	5.93	7.27	6.55	3.89	3.75	0.47	010
28003		A	Treatment of foot infection	9.06	8.38	7.72	4.91	4.87	0.75	090
28005		A	Treat foot bone lesion	9.44	NA	NA	5.95	5.84	0.72	090
28008		A	Incision of foot fascia	4.59	6.40	5.89	3.05	3.06	0.30	090
28010		A	Incision of toe tendon	2.97	3.02	2.82	2.47	2.40	0.19	090
28011		A	Incision of toe tendons	4.28	4.20	3.86	3.35	3.22	0.34	090
28020		A	Exploration of foot joint	5.15	8.17	7.33	3.98	3.83	0.48	090
28022		A	Exploration of foot joint	4.81	7.35	6.70	3.49	3.49	0.35	090
28024		A	Exploration of toe joint	4.52	6.97	6.42	3.28	3.34	0.31	090
28035		A	Decompression of tibia nerve	5.23	8.14	7.33	3.98	3.85	0.47	090
28039		A	Exc foot/toe tum sc > 1.5 cm	5.42	7.03	7.03	3.38	3.38	0.40	090
28041		A	Exc foot/toe tum deep >1.5cm	7.13	NA	NA	4.43	4.43	0.53	090
28043		A	Exc foot/toe tum sc < 1.5 cm	3.96	6.33	5.00	2.95	2.89	0.27	090
28045		A	Exc foot/toe tum deep <1.5cm	5.45	7.50	6.86	3.81	3.50	0.36	090
28046		A	Resect foot/toe tumor < 3 cm	12.38	NA	NA	6.94	6.29	1.03	090
28047		A	Resect foot/toe tumor > 3 cm	17.45	NA	NA	7.06	7.06	0.95	090
28050		A	Biopsy of foot joint lining	4.39	6.84	6.54	3.17	3.35	0.29	090
28052		A	Biopsy of foot joint lining	4.06	7.34	6.29	3.35	3.12	0.34	090
28054		A	Biopsy of toe joint lining	3.57	5.98	5.88	2.60	2.85	0.19	090
28055		A	Neurectomy, foot	6.29	NA	NA	3.61	3.61	0.39	090
28060		A	Partial removal, foot fascia	5.40	7.68	6.96	3.81	3.72	0.39	090
28062		A	Removal of foot fascia	6.69	8.26	7.72	3.96	3.94	0.43	090
28070		A	Removal of foot joint lining	5.24	7.67	6.98	3.62	3.61	0.40	090
28072		A	Removal of foot joint lining	4.72	8.42	7.45	4.01	3.91	0.46	090
28080		A	Removal of foot lesion	4.86	8.32	7.35	4.54	4.20	0.33	090
28086		A	Excise foot tendon sheath	4.92	8.72	8.01	4.25	4.08	0.52	090
28088		A	Excise foot tendon sheath	3.98	7.69	7.04	3.52	3.49	0.39	090
28090		A	Removal of foot lesion	4.55	7.36	6.62	3.43	3.33	0.34	090
28092		A	Removal of toe lesions	3.78	7.01	6.35	3.22	3.16	0.29	090
28100		A	Removal of ankle/heel lesion	5.83	9.09	8.43	4.51	4.36	0.54	090
28102		A	Remove/graft foot lesion	7.92	NA	NA	4.14	5.44	0.43	090
28103		A	Remove/graft foot lesion	6.67	NA	NA	3.70	4.29	0.36	090
28104		A	Removal of foot lesion	5.26	7.76	7.03	3.68	3.63	0.39	090
28106		A	Remove/graft foot lesion	7.35	NA	NA	4.00	4.32	0.40	090
28107		A	Remove/graft foot lesion	5.73	7.53	7.63	3.47	3.86	0.31	090
28108		A	Removal of toe lesions	4.30	6.80	6.12	3.16	3.10	0.28	090
28110		A	Part removal of metatarsal	4.22	7.42	6.73	3.25	3.17	0.29	090
28111		A	Part removal of metatarsal	5.15	7.71	7.17	3.49	3.43	0.42	090

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28112		A	Part removal of metatarsal	4.63	7.75	7.10	3.48	3.42	0.37	090
28113		A	Part removal of metatarsal	6.11	9.01	8.13	4.95	4.69	0.44	090
28114		A	Removal of metatarsal heads	12.00	15.36	13.68	9.59	8.79	1.15	090
28116		A	Revision of foot	9.14	10.02	9.04	5.60	5.38	0.67	090
28118		A	Removal of heel bone	6.13	8.74	7.93	4.43	4.29	0.53	090
28119		A	Removal of heel spur	5.56	7.79	7.02	3.82	3.69	0.38	090
28120		A	Part removal of ankle/heel	8.27	10.23	8.51	5.86	4.59	0.56	090
28122		A	Partial removal of foot bone	7.72	9.01	8.35	5.15	5.04	0.58	090
28124		A	Partial removal of toe	5.00	7.16	6.54	3.61	3.56	0.30	090
28126		A	Partial removal of toe	3.64	6.41	5.75	2.83	2.79	0.24	090
28130		A	Removal of ankle bone	9.50	NA	NA	6.88	6.44	1.32	090
28140		A	Removal of metatarsal	7.14	8.45	7.92	4.46	4.40	0.65	090
28150		A	Removal of toe	4.23	6.87	6.20	3.19	3.11	0.31	090
28153		A	Partial removal of toe	3.80	6.74	5.99	3.11	2.93	0.26	090
28160		A	Partial removal of toe	3.88	6.91	6.16	3.18	3.10	0.28	090
28171		A	Resect tarsal tumor	16.41	NA	NA	6.35	5.59	0.54	090
28173		A	Resect metatarsal tumor	14.16	NA	NA	6.49	5.28	0.72	090
28175		A	Resect phalanx of toe tumor	8.29	NA	NA	4.83	3.98	0.43	090
28190		A	Removal of foot foreign body	2.01	4.40	4.00	1.47	1.41	0.14	010
28192		A	Removal of foot foreign body	4.78	7.20	6.60	3.40	3.35	0.34	090
28193		A	Removal of foot foreign body	5.90	7.78	7.12	3.81	3.76	0.40	090
28200		A	Repair of foot tendon	4.74	7.26	6.64	3.36	3.35	0.33	090
28202		A	Repair/graft of foot tendon	7.07	8.24	7.83	4.11	4.15	0.46	090
28208		A	Repair of foot tendon	4.51	7.39	6.54	3.49	3.33	0.35	090
28210		A	Repair/graft of foot tendon	6.52	8.08	7.48	4.11	4.03	0.45	090
28220		A	Release of foot tendon	4.67	6.82	6.18	3.22	3.20	0.30	090
28222		A	Release of foot tendons	5.76	7.27	6.68	3.44	3.54	0.36	090
28225		A	Release of foot tendon	3.78	6.36	5.71	2.83	2.77	0.25	090
28226		A	Release of foot tendons	4.67	6.62	6.49	3.03	3.36	0.25	090
28230		A	Incision of foot tendon(s)	4.36	6.62	6.04	2.99	3.08	0.28	090
28232		A	Incision of toe tendon	3.51	6.37	5.79	2.84	2.86	0.24	090
28234		A	Incision of foot tendon	3.54	6.87	6.18	3.32	3.22	0.25	090
28238		A	Revision of foot tendon	7.96	9.29	8.45	4.80	4.66	0.62	090
28240		A	Release of big toe	4.48	6.84	6.22	3.14	3.16	0.31	090
28250		A	Revision of foot fascia	6.06	8.47	7.53	4.28	4.10	0.55	090
28260		A	Release of midfoot joint	8.19	9.62	8.35	5.25	4.89	0.73	090
28261		A	Revision of foot tendon	13.11	11.27	10.55	6.58	6.71	0.91	090
28262		A	Revision of foot and ankle	17.21	18.00	15.91	11.48	10.61	2.15	090
28264		A	Release of midfoot joint	10.65	8.80	9.82	4.83	6.24	0.58	090

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28270		A	Release of foot contracture	4.93	7.53	6.72	3.71	3.61	0.36	090
28272		A	Release of toe joint, each	3.92	6.12	5.58	2.73	2.72	0.22	090
28280		A	Fusion of toes	5.33	7.89	7.29	3.79	3.84	0.42	090
28285		A	Repair of hammertoe	4.76	7.24	6.51	3.57	3.46	0.33	090
28286		A	Repair of hammertoe	4.70	6.88	6.27	3.17	3.14	0.28	090
28288		A	Partial removal of foot bone	6.02	9.43	8.31	5.13	4.87	0.47	090
28289		A	Repair hallux rigidus	8.31	10.40	9.43	5.88	5.62	0.70	090
28290		A	Correction of bunion	5.83	8.98	8.03	4.33	4.24	0.50	090
28292		A	Correction of bunion	9.05	11.20	10.07	6.63	6.23	0.61	090
28293		A	Correction of bunion	11.48	15.24	13.96	7.17	6.89	0.66	090
28294		A	Correction of bunion	8.75	10.37	9.35	5.18	4.94	0.67	090
28296		A	Correction of bunion	8.35	9.96	9.29	5.29	5.22	0.55	090
28297		A	Correction of bunion	9.43	11.56	10.52	5.87	5.74	0.84	090
28298		A	Correction of bunion	8.13	10.23	9.21	5.01	4.86	0.62	090
28299		A	Correction of bunion	11.57	11.41	10.54	6.11	6.02	0.80	090
28300		A	Incision of heel bone	9.73	NA	NA	7.03	6.65	1.14	090
28302		A	Incision of ankle bone	9.74	NA	NA	8.01	6.83	1.37	090
28304		A	Incision of midfoot bones	9.41	10.88	9.76	5.81	5.56	0.86	090
28305		A	Incise/graft midfoot bones	10.77	NA	NA	6.64	6.52	0.59	090
28306		A	Incision of metatarsal	6.00	9.66	8.56	4.49	4.21	0.59	090
28307		A	Incision of metatarsal	6.50	12.74	10.92	6.18	5.26	0.91	090
28308		A	Incision of metatarsal	5.48	8.79	7.78	4.22	3.96	0.43	090
28309		A	Incision of metatarsals	14.16	NA	NA	8.84	8.06	1.50	090
28310		A	Revision of big toe	5.57	8.10	7.37	3.62	3.53	0.39	090
28312		A	Revision of toe	4.69	8.08	7.24	3.51	3.44	0.36	090
28313		A	Repair deformity of toe	5.15	8.38	7.37	4.17	4.13	0.50	090
28315		A	Removal of sesamoid bone	5.00	7.19	6.46	3.43	3.32	0.34	090
28320		A	Repair of foot bones	9.37	NA	NA	6.42	6.12	0.98	090
28322		A	Repair of metatarsals	8.53	11.45	10.16	6.32	5.88	0.93	090
28340		A	Resect enlarged toe tissue	7.15	7.84	7.60	3.81	4.00	0.39	090
28341		A	Resect enlarged toe	8.72	8.73	8.28	4.36	4.49	0.47	090
28344		A	Repair extra toe(s)	4.40	6.54	6.87	2.97	3.41	0.24	090
28345		A	Repair webbed toe(s)	6.09	7.39	7.47	3.56	4.04	0.33	090
28360		A	Reconstruct cleft foot	14.92	NA	NA	9.75	9.01	2.27	090
28400		A	Treatment of heel fracture	2.31	3.88	3.57	3.38	3.08	0.26	090
28405		A	Treatment of heel fracture	4.74	4.91	4.63	4.08	3.96	0.47	090
28406		A	Treatment of heel fracture	6.56	NA	NA	6.45	6.16	0.83	090
28415		A	Treat heel fracture	16.19	NA	NA	12.03	11.51	2.02	090
28420		A	Treat/graft heel fracture	17.52	NA	NA	13.69	12.01	2.48	090

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28430		A	Treatment of ankle fracture	2.22	3.62	3.30	2.99	2.69	0.25	090
28435		A	Treatment of ankle fracture	3.54	5.26	4.32	4.36	3.66	0.49	090
28436		A	Treatment of ankle fracture	4.90	NA	NA	6.12	5.51	0.68	090
28445		A	Treat ankle fracture	15.76	NA	NA	11.23	10.43	1.99	090
28446		A	Osteochondral talus autogrft	17.71	NA	NA	12.83	11.38	2.51	090
28450		A	Treat midfoot fracture, each	2.03	3.35	3.08	2.79	2.54	0.21	090
28455		A	Treat midfoot fracture, each	3.24	4.36	3.84	3.62	3.30	0.32	090
28456		A	Treat midfoot fracture	2.86	NA	NA	5.11	4.12	0.39	090
28465		A	Treat midfoot fracture, each	8.80	NA	NA	6.77	6.36	0.90	090
28470		A	Treat metatarsal fracture	2.03	3.24	3.00	2.74	2.50	0.23	090
28475		A	Treat metatarsal fracture	3.01	3.47	3.28	2.78	2.74	0.28	090
28476		A	Treat metatarsal fracture	3.60	NA	NA	4.89	4.70	0.38	090
28485		A	Treat metatarsal fracture	7.44	NA	NA	6.21	5.78	0.68	090
28490		A	Treat big toe fracture	1.17	2.43	2.17	1.95	1.75	0.12	090
28495		A	Treat big toe fracture	1.68	2.75	2.50	2.08	1.98	0.13	090
28496		A	Treat big toe fracture	2.48	8.15	7.68	3.30	3.10	0.25	090
28505		A	Treat big toe fracture	7.44	9.48	8.72	5.41	4.88	0.66	090
28510		A	Treatment of toe fracture	1.17	1.92	1.72	1.84	1.66	0.10	090
28515		A	Treatment of toe fracture	1.56	2.47	2.23	2.03	1.90	0.12	090
28525		A	Treat toe fracture	5.62	8.78	8.05	4.67	4.21	0.50	090
28530		A	Treat sesamoid bone fracture	1.11	1.82	1.65	1.50	1.41	0.08	090
28531		A	Treat sesamoid bone fracture	2.57	9.10	6.96	3.50	2.49	0.36	090
28540		A	Treat foot dislocation	2.19	2.92	2.70	2.45	2.34	0.14	090
28545		A	Treat foot dislocation	2.60	4.60	3.60	3.81	3.05	0.36	090
28546		A	Treat foot dislocation	3.40	10.57	8.47	4.91	4.13	0.47	090
28555		A	Repair foot dislocation	9.65	12.46	11.30	7.34	6.66	1.14	090
28570		A	Treat foot dislocation	1.76	2.39	2.38	1.84	1.92	0.09	090
28575		A	Treat foot dislocation	3.49	5.42	4.61	4.59	4.01	0.48	090
28576		A	Treat foot dislocation	4.60	NA	NA	5.14	4.23	0.64	090
28585		A	Repair foot dislocation	11.13	13.06	11.31	7.92	7.18	1.18	090
28600		A	Treat foot dislocation	2.02	3.43	3.10	2.70	2.53	0.20	090
28605		A	Treat foot dislocation	2.89	5.07	3.94	4.30	3.42	0.39	090
28606		A	Treat foot dislocation	5.09	NA	NA	4.80	4.42	0.60	090
28615		A	Repair foot dislocation	10.70	NA	NA	9.10	8.52	1.24	090
28630		A	Treat toe dislocation	1.75	2.13	1.87	1.06	0.98	0.16	010
28635		A	Treat toe dislocation	1.96	2.41	2.28	1.40	1.41	0.15	010
28636		A	Treat toe dislocation	2.77	4.84	4.30	2.26	2.18	0.29	010
28645		A	Repair toe dislocation	7.44	9.02	7.95	4.96	4.54	0.57	090
28660		A	Treat toe dislocation	1.28	1.57	1.37	0.95	0.84	0.14	010

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28665		A	Treat toe dislocation	1.97	2.02	1.82	1.47	1.40	0.17	010
28666		A	Treat toe dislocation	2.66	NA	NA	2.57	2.18	0.38	010
28675		A	Repair of toe dislocation	5.62	9.23	8.42	4.99	4.49	0.54	090
28705		A	Fusion of foot bones	20.33	NA	NA	12.63	11.86	2.48	090
28715		A	Fusion of foot bones	14.60	NA	NA	10.03	9.39	1.79	090
28725		A	Fusion of foot bones	12.18	NA	NA	7.88	7.50	1.33	090
28730		A	Fusion of foot bones	12.42	NA	NA	9.00	8.40	1.36	090
28735		A	Fusion of foot bones	12.23	NA	NA	8.04	7.60	1.26	090
28737		A	Revision of foot bones	11.03	NA	NA	6.57	6.48	0.91	090
28740		A	Fusion of foot bones	9.29	12.43	11.35	6.90	6.42	0.95	090
28750		A	Fusion of big toe joint	8.57	12.35	11.51	6.81	6.41	0.92	090
28755		A	Fusion of big toe joint	4.88	7.88	7.25	3.60	3.55	0.37	090
28760		A	Fusion of big toe joint	9.14	11.12	9.97	5.93	5.62	0.74	090
28800		A	Amputation of midfoot	8.79	NA	NA	5.59	5.40	0.93	090
28805		A	Amputation thru metatarsal	12.71	NA	NA	6.66	6.21	1.53	090
28810		A	Amputation toe & metatarsal	6.64	NA	NA	4.63	4.36	0.83	090
28820		A	Amputation of toe	5.00	8.32	7.84	3.92	3.74	0.52	090
28825		A	Partial amputation of toe	6.01	8.80	8.10	4.54	4.17	0.60	090
28890		A	High energy eswt, plantar f	3.45	5.20	4.98	2.51	2.28	0.25	090
28899		C	Foot/toes surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29000		A	Application of body cast	2.25	3.59	3.95	1.76	1.79	0.13	000
29010		A	Application of body cast	2.06	2.31	3.31	0.85	1.43	0.29	000
29015		A	Application of body cast	2.41	3.67	3.34	1.34	1.45	0.31	000
29020		A	Application of body cast	2.11	3.29	3.28	1.28	1.35	0.07	000
29025		A	Application of body cast	2.40	4.70	3.91	2.10	1.86	0.34	000
29035		A	Application of body cast	1.77	3.97	3.93	1.64	1.60	0.25	000
29040		A	Application of body cast	2.22	3.75	3.34	1.66	1.54	0.32	000
29044		A	Application of body cast	2.12	4.21	4.06	1.82	1.78	0.30	000
29046		A	Application of body cast	2.41	4.27	4.26	1.91	2.00	0.34	000
29049		A	Application of figure eight	0.89	1.52	1.22	0.84	0.63	0.13	000
29055		A	Application of shoulder cast	1.78	3.61	3.20	1.66	1.48	0.25	000
29058		A	Application of shoulder cast	1.31	1.48	1.34	0.69	0.68	0.17	000
29065		A	Application of long arm cast	0.87	1.49	1.36	0.84	0.76	0.12	000
29075		A	Application of forearm cast	0.77	1.43	1.31	0.79	0.71	0.10	000
29085		A	Apply hand/wrist cast	0.87	1.48	1.34	0.83	0.73	0.11	000
29086		A	Apply finger cast	0.62	1.31	1.13	0.69	0.59	0.06	000
29105		A	Apply long arm splint	0.87	1.29	1.18	0.65	0.57	0.11	000
29125		A	Apply forearm splint	0.59	1.15	1.03	0.52	0.45	0.07	000
29126		A	Apply forearm splint	0.77	1.21	1.09	0.60	0.52	0.08	000

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29130		A	Application of finger splint	0.50	0.52	0.47	0.24	0.21	0.06	000
29131		A	Application of finger splint	0.55	0.73	0.67	0.31	0.27	0.06	000
29200		A	Strapping of chest	0.65	0.75	0.66	0.43	0.37	0.04	000
29240		A	Strapping of shoulder	0.71	0.75	0.72	0.44	0.40	0.04	000
29260		A	Strapping of elbow or wrist	0.55	0.76	0.70	0.43	0.38	0.05	000
29280		A	Strapping of hand or finger	0.51	0.76	0.71	0.43	0.38	0.04	000
29305		A	Application of hip cast	2.03	3.96	3.56	1.92	1.76	0.29	000
29325		A	Application of hip casts	2.32	4.32	3.89	2.12	1.96	0.33	000
29345		A	Application of long leg cast	1.40	1.95	1.78	1.13	1.04	0.19	000
29355		A	Application of long leg cast	1.53	1.93	1.76	1.14	1.06	0.20	000
29358		A	Apply long leg cast brace	1.43	2.47	2.20	1.16	1.06	0.20	000
29365		A	Application of long leg cast	1.18	1.83	1.68	1.01	0.94	0.16	000
29405		A	Apply short leg cast	0.86	1.37	1.26	0.76	0.70	0.10	000
29425		A	Apply short leg cast	1.01	1.38	1.27	0.74	0.71	0.10	000
29435		A	Apply short leg cast	1.18	1.75	1.61	0.95	0.89	0.16	000
29440		A	Addition of walker to cast	0.57	0.75	0.69	0.31	0.28	0.06	000
29445		A	Apply rigid leg cast	1.78	1.78	1.68	1.02	0.95	0.17	000
29450		A	Application of leg cast	2.08	1.65	1.57	0.91	0.94	0.15	000
29505		A	Application, long leg splint	0.69	1.28	1.15	0.56	0.49	0.09	000
29515		A	Application lower leg splint	0.73	1.12	0.99	0.55	0.49	0.07	000
29520		A	Strapping of hip	0.54	0.71	0.68	0.40	0.38	0.03	000
29530		A	Strapping of knee	0.57	0.74	0.70	0.41	0.37	0.05	000
29540		A	Strapping of ankle and/or ft	0.51	0.57	0.53	0.31	0.31	0.03	000
29550		A	Strapping of toes	0.47	0.59	0.54	0.31	0.30	0.03	000
29580		A	Application of paste boot	0.55	0.79	0.73	0.38	0.35	0.05	000
29581		A	Apply multlay comprs lwr leg	0.60	1.74	1.74	0.23	0.23	0.06	000
29590		A	Application of foot splint	0.76	0.63	0.59	0.26	0.27	0.04	000
29700		A	Removal/revision of cast	0.57	1.03	0.97	0.29	0.28	0.07	000
29705		A	Removal/revision of cast	0.76	0.91	0.83	0.45	0.40	0.10	000
29710		A	Removal/revision of cast	1.34	1.69	1.49	0.76	0.67	0.19	000
29715		A	Removal/revision of cast	0.94	1.08	1.17	0.43	0.44	0.09	000
29720		A	Repair of body cast	0.68	1.35	1.23	0.42	0.39	0.09	000
29730		A	Windowing of cast	0.75	0.88	0.80	0.41	0.37	0.09	000
29740		A	Wedging of cast	1.12	1.13	1.08	0.52	0.50	0.12	000
29750		A	Wedging of clubfoot cast	1.26	1.38	1.18	0.71	0.62	0.18	000
29799		C	Casting/strapping procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29800		A	Jaw arthroscopy/surgery	6.84	NA	NA	6.21	5.77	0.96	090
29804		A	Jaw arthroscopy/surgery	8.87	NA	NA	7.64	6.79	1.24	090
29805		A	Shoulder arthroscopy, dx	6.03	NA	NA	5.64	5.28	0.84	090

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29806		A	Shoulder arthroscopy/surgery	15.14	NA	NA	11.35	10.58	2.13	090
29807		A	Shoulder arthroscopy/surgery	14.67	NA	NA	11.15	10.40	2.06	090
29819		A	Shoulder arthroscopy/surgery	7.79	NA	NA	6.77	6.34	1.08	090
29820		A	Shoulder arthroscopy/surgery	7.21	NA	NA	6.21	5.82	1.00	090
29821		A	Shoulder arthroscopy/surgery	7.89	NA	NA	6.83	6.37	1.10	090
29822		A	Shoulder arthroscopy/surgery	7.60	NA	NA	6.72	6.26	1.06	090
29823		A	Shoulder arthroscopy/surgery	8.36	NA	NA	7.30	6.80	1.16	090
29824		A	Shoulder arthroscopy/surgery	8.98	NA	NA	7.90	7.29	1.24	090
29825		A	Shoulder arthroscopy/surgery	7.79	NA	NA	6.79	6.33	1.09	090
29826		A	Shoulder arthroscopy/surgery	9.16	NA	NA	7.48	6.99	1.28	090
29827		A	Arthroscop rotator cuff repr	15.59	NA	NA	11.34	10.63	2.20	090
29828		A	Arthroscopy biceps tenodesis	13.16	NA	NA	9.97	8.99	1.86	090
29830		A	Elbow arthroscopy	5.88	NA	NA	5.38	5.02	0.82	090
29834		A	Elbow arthroscopy/surgery	6.42	NA	NA	5.85	5.46	0.87	090
29835		A	Elbow arthroscopy/surgery	6.62	NA	NA	5.95	5.55	0.93	090
29836		A	Elbow arthroscopy/surgery	7.72	NA	NA	6.77	6.33	1.08	090
29837		A	Elbow arthroscopy/surgery	7.01	NA	NA	6.15	5.74	0.96	090
29838		A	Elbow arthroscopy/surgery	7.88	NA	NA	6.84	6.40	1.06	090
29840		A	Wrist arthroscopy	5.68	NA	NA	5.49	5.12	0.79	090
29843		A	Wrist arthroscopy/surgery	6.15	NA	NA	5.81	5.43	0.86	090
29844		A	Wrist arthroscopy/surgery	6.51	NA	NA	5.97	5.48	0.84	090
29845		A	Wrist arthroscopy/surgery	7.69	NA	NA	6.61	6.12	0.98	090
29846		A	Wrist arthroscopy/surgery	6.89	NA	NA	6.16	5.71	0.88	090
29847		A	Wrist arthroscopy/surgery	7.22	NA	NA	6.24	5.86	1.01	090
29848		A	Wrist endoscopy/surgery	6.39	NA	NA	6.35	5.76	0.82	090
29850		A	Knee arthroscopy/surgery	8.27	NA	NA	7.20	5.83	1.16	090
29851		A	Knee arthroscopy/surgery	13.26	NA	NA	9.96	9.28	1.88	090
29855		A	Tibial arthroscopy/surgery	10.76	NA	NA	8.84	8.23	1.52	090
29856		A	Tibial arthroscopy/surgery	14.28	NA	NA	10.56	9.90	2.03	090
29860		A	Hip arthroscopy, dx	9.00	NA	NA	7.56	6.83	1.26	090
29861		A	Hip arthroscopy/surgery	10.10	NA	NA	8.10	7.37	1.42	090
29862		A	Hip arthroscopy/surgery	11.17	NA	NA	9.21	8.46	1.56	090
29863		A	Hip arthroscopy/surgery	11.17	NA	NA	9.25	8.41	1.57	090
29866		A	Autgrft implnt, knee w/scope	14.67	NA	NA	11.45	10.61	2.08	090
29867		A	Allgrft implnt, knee w/scope	18.39	NA	NA	13.51	12.35	2.60	090
29868		A	Meniscal trnspl, knee w/scpe	25.10	NA	NA	16.80	15.44	3.55	090
29870		A	Knee arthroscopy, dx	5.19	9.05	5.68	5.02	4.66	0.72	090
29871		A	Knee arthroscopy/drainage	6.69	NA	NA	6.06	5.63	0.93	090
29873		A	Knee arthroscopy/surgery	6.24	NA	NA	6.70	6.22	0.86	090

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29874		A	Knee arthroscopy/surgery	7.19	NA	NA	6.17	5.76	1.00	090
29875		A	Knee arthroscopy/surgery	6.45	NA	NA	5.85	5.47	0.90	090
29876		A	Knee arthroscopy/surgery	8.87	NA	NA	7.46	6.88	1.23	090
29877		A	Knee arthroscopy/surgery	8.30	NA	NA	7.19	6.63	1.16	090
29879		A	Knee arthroscopy/surgery	8.99	NA	NA	7.52	6.95	1.25	090
29880		A	Knee arthroscopy/surgery	9.45	NA	NA	7.75	7.17	1.32	090
29881		A	Knee arthroscopy/surgery	8.71	NA	NA	7.39	6.82	1.21	090
29882		A	Knee arthroscopy/surgery	9.60	NA	NA	7.79	7.17	1.34	090
29883		A	Knee arthroscopy/surgery	11.77	NA	NA	9.18	8.57	1.66	090
29884		A	Knee arthroscopy/surgery	8.28	NA	NA	7.19	6.62	1.15	090
29885		A	Knee arthroscopy/surgery	10.21	NA	NA	8.49	7.82	1.43	090
29886		A	Knee arthroscopy/surgery	8.49	NA	NA	7.31	6.74	1.18	090
29887		A	Knee arthroscopy/surgery	10.16	NA	NA	8.44	7.77	1.42	090
29888		A	Knee arthroscopy/surgery	14.30	NA	NA	10.48	9.70	2.02	090
29889		A	Knee arthroscopy/surgery	17.41	NA	NA	13.00	12.08	2.44	090
29891		A	Ankle arthroscopy/surgery	9.67	NA	NA	7.79	7.29	1.17	090
29892		A	Ankle arthroscopy/surgery	10.27	NA	NA	8.82	7.37	1.44	090
29893		A	Scope, plantar fasciotomy	6.32	9.28	8.44	4.84	4.59	0.36	090
29894		A	Ankle arthroscopy/surgery	7.35	NA	NA	5.63	5.24	0.88	090
29895		A	Ankle arthroscopy/surgery	7.13	NA	NA	5.29	5.02	0.79	090
29897		A	Ankle arthroscopy/surgery	7.32	NA	NA	5.71	5.41	0.88	090
29898		A	Ankle arthroscopy/surgery	8.49	NA	NA	6.06	5.75	0.93	090
29899		A	Ankle arthroscopy/surgery	15.41	NA	NA	10.90	10.18	2.06	090
29900		A	Mcp joint arthroscopy, dx	5.88	NA	NA	4.44	4.92	0.29	090
29901		A	Mcp joint arthroscopy, surg	6.59	NA	NA	6.57	5.69	0.92	090
29902		A	Mcp joint arthroscopy, surg	7.16	NA	NA	7.96	6.23	1.84	090
29904		A	Subtalar arthro w/fb rmvl	8.65	NA	NA	7.20	6.47	1.21	090
29905		A	Subtalar arthro w/exc	9.18	NA	NA	7.95	7.14	1.28	090
29906		A	Subtalar arthro w/deb	9.65	NA	NA	8.39	7.53	1.34	090
29907		A	Subtalar arthro w/fusion	12.18	NA	NA	9.63	8.66	1.72	090
29999		C	Arthroscopy of joint	0.00	0.00	0.00	0.00	0.00	0.00	YYY
30000		A	Drainage of nose lesion	1.48	4.37	4.19	1.59	1.46	0.14	010
30020		A	Drainage of nose lesion	1.48	4.41	4.06	1.62	1.48	0.14	010
3008F		I	Body mass index docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30100		A	Intranasal biopsy	0.94	2.66	2.51	0.85	0.81	0.09	000
30110		A	Removal of nose polyp(s)	1.68	4.18	3.89	1.72	1.58	0.15	010
30115		A	Removal of nose polyp(s)	4.44	NA	NA	6.67	6.22	0.41	090
30117		A	Removal of intranasal lesion	3.26	18.66	17.45	5.42	5.06	0.30	090
30118		A	Removal of intranasal lesion	9.92	NA	NA	9.96	9.23	0.94	090

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30120		A	Revision of nose	5.39	7.71	7.35	5.78	5.64	0.61	090
30124		A	Removal of nose lesion	3.20	NA	NA	3.86	3.57	0.29	090
30125		A	Removal of nose lesion	7.30	NA	NA	8.51	7.97	0.67	090
30130		A	Excise inferior turbinate	3.47	NA	NA	6.28	5.88	0.32	090
30140		A	Resect inferior turbinate	3.57	NA	NA	7.68	7.17	0.32	090
30150		A	Partial removal of nose	9.55	NA	NA	10.34	9.88	1.01	090
3015F		I	Cerv cancer screen docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30160		A	Removal of nose	9.99	NA	NA	10.20	9.61	0.91	090
3018F		I	Pre-prxd rsk et al docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30200		A	Injection treatment of nose	0.78	2.13	1.98	0.79	0.73	0.07	000
30210		A	Nasal sinus therapy	1.13	2.70	2.52	1.46	1.35	0.10	010
30220		A	Insert nasal septal button	1.59	6.09	5.64	1.68	1.55	0.15	010
30300		A	Remove nasal foreign body	1.09	4.68	4.49	2.13	1.97	0.10	010
30310		A	Remove nasal foreign body	2.01	NA	NA	3.28	3.08	0.18	010
30320		A	Remove nasal foreign body	4.64	NA	NA	7.01	6.58	0.42	090
3038F		I	Pulm fx w/in 12 mon b/4 surg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
30400		R	Reconstruction of nose	10.86	NA	NA	15.20	14.78	0.98	090
30410		R	Reconstruction of nose	14.00	NA	NA	16.72	16.20	1.27	090
30420		R	Reconstruction of nose	16.90	NA	NA	18.53	17.29	1.73	090
30430		R	Revision of nose	8.24	NA	NA	13.94	14.15	1.13	090
30435		R	Revision of nose	12.73	NA	NA	16.11	16.51	1.15	090
30450		R	Revision of nose	19.66	NA	NA	19.44	19.08	1.81	090
30460		A	Revision of nose	10.32	NA	NA	10.30	8.76	1.46	090
30462		A	Revision of nose	20.28	NA	NA	16.51	16.69	2.88	090
30465		A	Repair nasal stenosis	12.36	NA	NA	13.05	12.02	1.24	090
30520		A	Repair of nasal septum	7.01	NA	NA	9.16	8.21	0.64	090
30540		A	Repair nasal defect	7.92	NA	NA	9.91	8.89	0.72	090
30545		A	Repair nasal defect	11.62	NA	NA	10.36	11.31	0.58	090
30560		A	Release of nasal adhesions	1.31	5.51	5.29	2.24	2.13	0.12	010
30580		A	Repair upper jaw fistula	6.88	9.56	8.64	6.25	5.48	0.63	090
30600		A	Repair mouth/nose fistula	6.16	8.64	8.08	5.12	4.74	0.56	090
30620		A	Intranasal reconstruction	6.16	NA	NA	9.74	9.16	0.64	090
30630		A	Repair nasal septum defect	7.29	NA	NA	8.84	8.22	0.69	090
30801		A	Ablate inf turbinate, superf	1.14	4.59	4.41	2.35	2.18	0.10	010
30802		A	Ablate inf turbinate submuc	2.08	5.31	5.05	2.84	2.61	0.19	010
30901		A	Control of nosebleed	1.21	1.46	1.36	0.42	0.35	0.13	000
30903		A	Control of nosebleed	1.54	3.56	3.26	0.59	0.50	0.16	000
30905		A	Control of nosebleed	1.97	4.33	3.99	0.70	0.63	0.21	000
30906		A	Repeat control of nosebleed	2.45	4.69	4.37	1.09	0.98	0.24	000

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30915		A	Ligation, nasal sinus artery	7.44	NA	NA	7.65	6.96	0.70	090
30920		A	Ligation, upper jaw artery	11.14	NA	NA	10.68	9.61	1.03	090
30930		A	Ther fx, nasal inf turbinate	1.31	NA	NA	1.88	1.73	0.12	010
30999		C	Nasal surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31000		A	Irrigation, maxillary sinus	1.20	3.36	3.21	1.50	1.42	0.10	010
31002		A	Irrigation, sphenoid sinus	1.96	NA	NA	3.16	3.03	0.18	010
31020		A	Exploration, maxillary sinus	3.07	8.99	8.78	5.97	5.67	0.28	090
31030		A	Exploration, maxillary sinus	6.01	11.40	11.06	7.44	6.90	0.54	090
31032		A	Explore sinus, remove polyps	6.69	NA	NA	8.10	7.48	0.62	090
31040		A	Exploration behind upper jaw	9.77	NA	NA	9.69	8.83	0.99	090
31050		A	Exploration, sphenoid sinus	5.37	NA	NA	7.34	6.86	0.49	090
31051		A	Sphenoid sinus surgery	7.25	NA	NA	9.46	8.77	0.66	090
31070		A	Exploration of frontal sinus	4.40	NA	NA	6.89	6.43	0.41	090
31075		A	Exploration of frontal sinus	9.51	NA	NA	10.80	10.02	0.87	090
31080		A	Removal of frontal sinus	12.74	NA	NA	14.07	12.54	1.16	090
31081		A	Removal of frontal sinus	14.19	NA	NA	20.46	16.68	3.64	090
31084		A	Removal of frontal sinus	14.95	NA	NA	15.13	14.35	1.36	090
31085		A	Removal of frontal sinus	15.64	NA	NA	21.13	16.37	4.01	090
31086		A	Removal of frontal sinus	14.36	NA	NA	14.85	13.60	1.31	090
31087		A	Removal of frontal sinus	14.57	NA	NA	13.70	12.75	1.33	090
31090		A	Exploration of sinuses	11.17	NA	NA	15.31	13.97	1.02	090
31200		A	Removal of ethmoid sinus	5.14	NA	NA	8.95	8.33	0.52	090
31201		A	Removal of ethmoid sinus	8.60	NA	NA	10.50	9.59	0.80	090
31205		A	Removal of ethmoid sinus	10.58	NA	NA	12.16	10.97	1.13	090
31225		A	Removal of upper jaw	26.70	NA	NA	22.22	19.58	2.55	090
31230		A	Removal of upper jaw	30.82	NA	NA	23.86	20.98	2.85	090
31231		A	Nasal endoscopy, dx	1.10	3.77	3.63	0.93	0.86	0.10	000
31233		A	Nasal/sinus endoscopy, dx	2.18	4.60	4.41	1.45	1.32	0.20	000
31235		A	Nasal/sinus endoscopy, dx	2.64	5.05	4.89	1.66	1.51	0.24	000
31237		A	Nasal/sinus endoscopy, surg	2.98	5.36	5.14	1.84	1.66	0.28	000
31238		A	Nasal/sinus endoscopy, surg	3.26	5.33	5.11	1.98	1.79	0.30	000
31239		A	Nasal/sinus endoscopy, surg	9.33	NA	NA	8.47	7.49	0.89	010
31240		A	Nasal/sinus endoscopy, surg	2.61	NA	NA	1.66	1.51	0.24	000
31254		A	Revision of ethmoid sinus	4.64	NA	NA	2.65	2.39	0.43	000
31255		A	Removal of ethmoid sinus	6.95	NA	NA	3.74	3.38	0.64	000
31256		A	Exploration maxillary sinus	3.29	NA	NA	1.99	1.80	0.31	000
31267		A	Endoscopy, maxillary sinus	5.45	NA	NA	3.03	2.73	0.51	000
31276		A	Sinus endoscopy, surgical	8.84	NA	NA	4.66	4.18	0.82	000
31287		A	Nasal/sinus endoscopy, surg	3.91	NA	NA	2.29	2.07	0.36	000

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31288		A	Nasal/sinus endoscopy, surg	4.57	NA	NA	2.61	2.36	0.43	000
31290		A	Nasal/sinus endoscopy, surg	18.61	NA	NA	11.92	10.75	1.91	010
31291		A	Nasal/sinus endoscopy, surg	19.56	NA	NA	12.40	11.21	2.26	010
31292		A	Nasal/sinus endoscopy, surg	15.90	NA	NA	10.61	9.54	1.49	010
31293		A	Nasal/sinus endoscopy, surg	17.47	NA	NA	11.37	10.25	1.62	010
31294		A	Nasal/sinus endoscopy, surg	20.31	NA	NA	12.74	11.45	1.89	010
31299		C	Sinus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31300		A	Removal of larynx lesion	15.91	NA	NA	17.25	15.74	1.46	090
31320		A	Diagnostic incision, larynx	5.73	NA	NA	11.11	10.50	0.52	090
31360		A	Removal of larynx	29.91	NA	NA	24.69	21.22	2.81	090
31365		A	Removal of larynx	38.81	NA	NA	29.01	24.84	3.64	090
31367		A	Partial removal of larynx	30.57	NA	NA	27.24	24.25	2.85	090
31368		A	Partial removal of larynx	34.19	NA	NA	29.99	26.82	3.15	090
31370		A	Partial removal of larynx	27.57	NA	NA	26.66	23.96	2.54	090
31375		A	Partial removal of larynx	26.07	NA	NA	25.39	22.74	2.40	090
31380		A	Partial removal of larynx	25.57	NA	NA	25.15	22.49	2.35	090
31382		A	Partial removal of larynx	28.57	NA	NA	27.14	24.17	2.63	090
31390		A	Removal of larynx & pharynx	42.51	NA	NA	31.96	28.10	4.21	090
31395		A	Reconstruct larynx & pharynx	43.80	NA	NA	35.37	31.10	4.04	090
31400		A	Revision of larynx	11.60	NA	NA	14.32	13.49	1.06	090
31420		A	Removal of epiglottis	11.43	NA	NA	10.48	9.57	1.05	090
31500		A	Insert emergency airway	2.33	NA	NA	0.51	0.48	0.22	000
31502		A	Change of windpipe airway	0.65	NA	NA	0.28	0.25	0.06	000
31505		A	Diagnostic laryngoscopy	0.61	1.51	1.47	0.68	0.63	0.06	000
31510		A	Laryngoscopy with biopsy	1.92	3.48	3.36	1.28	1.17	0.18	000
31511		A	Remove foreign body, larynx	2.16	3.24	3.10	1.24	1.13	0.22	000
31512		A	Removal of larynx lesion	2.07	3.30	3.14	1.40	1.26	0.19	000
31513		A	Injection into vocal cord	2.10	NA	NA	1.42	1.29	0.20	000
31515		A	Laryngoscopy for aspiration	1.80	3.51	3.42	1.11	1.01	0.18	000
31520		A	Dx laryngoscopy, newborn	2.56	NA	NA	1.64	1.41	0.24	000
31525		A	Dx laryngoscopy excl nb	2.63	3.84	3.64	1.61	1.46	0.24	000
31526		A	Dx laryngoscopy w/oper scope	2.57	NA	NA	1.64	1.49	0.24	000
31527		A	Laryngoscopy for treatment	3.27	NA	NA	1.98	1.72	0.30	000
31528		A	Laryngoscopy and dilation	2.37	NA	NA	1.49	1.34	0.23	000
31529		A	Laryngoscopy and dilation	2.68	NA	NA	1.63	1.49	0.25	000
31530		A	Laryngoscopy w/fb removal	3.38	NA	NA	1.89	1.71	0.33	000
31531		A	Laryngoscopy w/fb & op scope	3.58	NA	NA	2.12	1.92	0.33	000
31535		A	Laryngoscopy w/biopsy	3.16	NA	NA	1.92	1.73	0.30	000
31536		A	Laryngoscopy w/bx & op scope	3.55	NA	NA	2.11	1.91	0.33	000

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31540		A	Laryngoscopy w/exc of tumor	4.12	NA	NA	2.38	2.15	0.39	000
31541		A	Larynscop w/tumr exc + scope	4.52	NA	NA	2.58	2.33	0.42	000
31545		A	Remove vc lesion w/scope	6.30	NA	NA	3.47	3.08	0.58	000
31546		A	Remove vc lesion scope/graft	9.73	NA	NA	5.13	4.44	0.90	000
31560		A	Laryngoscop w/arytenoidectom	5.45	NA	NA	3.00	2.68	0.50	000
31561		A	Larynscop, remve cart + scop	5.99	NA	NA	3.23	2.89	0.56	000
31570		A	Laryngoscope w/vc inj	3.86	4.81	4.77	2.20	2.01	0.39	000
31571		A	Laryngoscop w/vc inj + scope	4.26	NA	NA	2.46	2.21	0.40	000
31575		A	Diagnostic laryngoscopy	1.10	1.86	1.80	0.93	0.85	0.10	000
31576		A	Laryngoscopy with biopsy	1.97	3.78	3.68	1.32	1.20	0.17	000
31577		A	Remove foreign body, larynx	2.47	3.76	3.60	1.50	1.36	0.23	000
31578		A	Removal of larynx lesion	2.84	4.41	4.22	1.77	1.54	0.26	000
31579		A	Diagnostic laryngoscopy	2.26	3.21	3.18	1.49	1.35	0.21	000
31580		A	Revision of larynx	14.66	NA	NA	17.17	15.67	1.34	090
31582		A	Revision of larynx	23.22	NA	NA	26.19	24.65	2.14	090
31584		A	Treat larynx fracture	20.47	NA	NA	19.10	17.52	1.90	090
31587		A	Revision of larynx	15.27	NA	NA	11.24	9.81	1.41	090
31588		A	Revision of larynx	14.99	NA	NA	14.90	13.65	1.36	090
31590		A	Reinnervate larynx	7.85	NA	NA	15.01	14.44	0.71	090
31595		A	Larynx nerve surgery	8.84	NA	NA	11.02	10.36	0.81	090
31599		C	Larynx surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31600		A	Incision of windpipe	7.17	NA	NA	3.05	2.77	0.91	000
31601		A	Incision of windpipe	4.44	NA	NA	2.51	2.25	0.41	000
31603		A	Incision of windpipe	4.14	NA	NA	1.65	1.48	0.50	000
31605		A	Incision of windpipe	3.57	NA	NA	1.09	1.01	0.46	000
31610		A	Incision of windpipe	9.38	NA	NA	9.16	8.38	0.95	090
31611		A	Surgery/speech prosthesis	6.00	NA	NA	8.00	7.44	0.56	090
31612		A	Puncture/clear windpipe	0.91	1.17	1.11	0.35	0.31	0.09	000
31613		A	Repair windpipe opening	4.71	NA	NA	6.91	6.41	0.52	090
31614		A	Repair windpipe opening	8.63	NA	NA	10.92	9.96	0.83	090
31615		A	Visualization of windpipe	2.09	2.58	2.51	1.30	1.18	0.19	000
31620		A	Endobronchial us add-on	1.40	5.22	5.74	0.40	0.41	0.10	ZZZ
31622		A	Dx bronchoscope/wash	2.78	4.89	5.25	1.04	1.00	0.24	000
31623		A	Dx bronchoscope/brush	2.88	5.27	5.88	1.02	0.97	0.18	000
31624		A	Dx bronchoscope/lavage	2.88	4.81	5.29	1.03	0.99	0.18	000
31625		A	Bronchoscopy w/biopsy(s)	3.36	4.96	5.42	1.17	1.12	0.23	000
31626		A	Bronchoscopy w/markers	4.16	7.33	7.33	1.46	1.46	0.23	000
31627		A	Navigational bronchoscopy	2.00	30.18	30.18	0.73	0.73	0.11	ZZZ
31628		A	Bronchoscopy/lung bx, each	3.80	5.68	6.64	1.27	1.21	0.22	000

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31629		A	Bronchoscopy/needle bx, each	4.09	10.36	11.98	1.36	1.30	0.25	000
31630		A	Bronchoscopy dilate/fx repr	3.81	NA	NA	1.46	1.45	0.36	000
31631		A	Bronchoscopy, dilate w/stent	4.36	NA	NA	1.64	1.60	0.43	000
31632		A	Bronchoscopy/lung bx, addl	1.03	0.81	0.84	0.30	0.27	0.06	ZZZ
31633		A	Bronchoscopy/needle bx addl	1.32	0.94	0.97	0.38	0.36	0.08	ZZZ
31635		A	Bronchoscopy w/fb removal	3.67	4.85	5.31	1.30	1.27	0.29	000
31636		A	Bronchoscopy, bronch stents	4.30	NA	NA	1.50	1.52	0.41	000
31637		A	Bronchoscopy, stent add-on	1.58	NA	NA	0.42	0.46	0.09	ZZZ
31638		A	Bronchoscopy, revise stent	4.88	NA	NA	1.77	1.75	0.47	000
31640		A	Bronchoscopy w/tumor excise	4.93	NA	NA	1.79	1.77	0.46	000
31641		A	Bronchoscopy, treat blockage	5.02	NA	NA	1.77	1.69	0.42	000
31643		A	Diag bronchoscope/catheter	3.49	NA	NA	1.15	1.13	0.21	000
31645		A	Bronchoscopy, clear airways	3.16	4.33	4.71	1.11	1.06	0.20	000
31646		A	Bronchoscopy, reclear airway	2.72	4.04	4.43	0.97	0.93	0.18	000
31656		A	Bronchoscopy, inj for x-ray	2.17	5.09	5.91	0.76	0.76	0.12	000
31715		A	Injection for bronchus x-ray	1.11	NA	NA	0.29	0.33	0.06	000
31717		A	Bronchial brush biopsy	2.12	4.15	5.33	0.74	0.75	0.12	000
31720		A	Clearance of airways	1.06	NA	NA	0.31	0.30	0.06	000
31725		A	Clearance of airways	1.96	NA	NA	0.55	0.49	0.14	000
31730		A	Intro, windpipe wire/tube	2.85	25.91	21.27	0.99	0.91	0.33	000
31750		A	Repair of windpipe	15.39	NA	NA	19.67	18.39	1.64	090
31755		A	Repair of windpipe	17.54	NA	NA	27.07	25.46	1.60	090
31760		A	Repair of windpipe	23.48	NA	NA	10.62	10.90	3.96	090
31766		A	Reconstruction of windpipe	31.67	NA	NA	14.96	13.33	5.37	090
31770		A	Repair/graft of bronchus	23.54	NA	NA	9.60	9.70	3.98	090
31775		A	Reconstruct bronchus	24.59	NA	NA	10.20	9.88	4.16	090
31780		A	Reconstruct windpipe	19.84	NA	NA	11.14	10.24	2.33	090
31781		A	Reconstruct windpipe	24.85	NA	NA	13.99	11.72	4.21	090
31785		A	Remove windpipe lesion	18.35	NA	NA	10.17	9.13	1.90	090
31786		A	Remove windpipe lesion	25.42	NA	NA	10.45	11.29	4.30	090
31800		A	Repair of windpipe injury	8.18	NA	NA	10.37	9.41	0.75	090
31805		A	Repair of windpipe injury	13.42	NA	NA	7.98	7.26	2.27	090
31820		A	Closure of windpipe lesion	4.64	6.59	6.11	3.95	3.60	0.47	090
31825		A	Repair of windpipe defect	7.07	8.55	7.94	5.55	5.09	0.70	090
31830		A	Revise windpipe scar	4.62	6.59	6.17	4.18	3.89	0.50	090
31899		C	Airways surgical procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
32035		A	Exploration of chest	11.29	NA	NA	6.77	6.45	1.85	090
32036		A	Exploration of chest	12.30	NA	NA	7.14	6.86	2.09	090
32095		A	Biopsy through chest wall	10.14	NA	NA	5.76	5.55	1.71	090

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32100		A	Exploration/biopsy of chest	16.16	NA	NA	7.82	7.71	2.74	090
32110		A	Explore/repair chest	25.28	NA	NA	11.37	10.89	4.14	090
32120		A	Re-exploration of chest	14.39	NA	NA	7.52	7.35	2.44	090
32124		A	Explore chest free adhesions	15.45	NA	NA	7.92	7.59	2.63	090
32140		A	Removal of lung lesion(s)	16.66	NA	NA	8.43	8.03	2.81	090
32141		A	Remove/treat lung lesions	27.18	NA	NA	11.43	10.65	4.63	090
32150		A	Removal of lung lesion(s)	16.82	NA	NA	8.40	8.03	2.84	090
32151		A	Remove lung foreign body	16.94	NA	NA	8.10	8.30	2.86	090
32160		A	Open chest heart massage	13.10	NA	NA	6.60	6.17	2.16	090
32200		A	Drain, open, lung lesion	18.68	NA	NA	9.90	9.39	3.07	090
32201		A	Drain, percut, lung lesion	3.99	17.80	19.81	1.19	1.45	0.28	000
32215		A	Treat chest lining	13.05	NA	NA	7.10	6.91	2.19	090
32220		A	Release of lung	26.65	NA	NA	13.32	13.06	4.53	090
32225		A	Partial release of lung	16.75	NA	NA	8.30	8.05	2.83	090
32310		A	Removal of chest lining	15.28	NA	NA	7.84	7.57	2.61	090
32320		A	Free/remove chest lining	27.25	NA	NA	13.02	12.59	4.56	090
32400		A	Needle biopsy chest lining	1.76	1.93	2.14	0.52	0.59	0.12	000
32402		A	Open biopsy chest lining	8.97	NA	NA	5.31	5.18	1.47	090
32405		A	Biopsy, lung or mediastinum	1.93	0.57	0.71	0.57	0.70	0.13	000
32420		A	Puncture/clear lung	2.18	NA	NA	0.65	0.75	0.17	000
32421		A	Thoracentesis for aspiration	1.54	2.22	2.53	0.48	0.50	0.11	000
32422		A	Thoracentesis w/tube insert	2.19	2.65	2.95	1.00	1.08	0.15	000
32440		A	Removal of lung	27.28	NA	NA	12.21	12.19	4.60	090
32442		A	Sleeve pneumonectomy	56.47	NA	NA	16.99	18.19	3.08	090
32445		A	Removal of lung	63.84	NA	NA	24.18	22.60	10.80	090
32480		A	Partial removal of lung	25.82	NA	NA	11.51	11.44	4.38	090
32482		A	Bilobectomy	27.44	NA	NA	12.52	12.41	4.64	090
32484		A	Segmentectomy	25.38	NA	NA	10.82	10.75	4.28	090
32486		A	Sleeve lobectomy	42.88	NA	NA	16.25	15.68	7.35	090
32488		A	Completion pneumonectomy	42.99	NA	NA	17.18	16.36	7.32	090
32491		R	Lung volume reduction	25.24	NA	NA	11.55	11.98	4.25	090
32500		A	Partial removal of lung	24.64	NA	NA	11.54	11.52	4.18	090
32501		A	Repair bronchus add-on	4.68	NA	NA	1.48	1.52	0.79	ZZZ
32503		A	Resect apical lung tumor	31.74	NA	NA	13.39	13.57	5.41	090
32504		A	Resect apical lung tum/chest	36.54	NA	NA	15.04	15.39	6.15	090
32540		A	Removal of lung lesion	30.35	NA	NA	13.19	12.40	5.14	090
32550		A	Insert pleural cath	4.17	15.00	16.12	1.57	1.65	0.51	000
32551		A	Insertion of chest tube	3.29	NA	NA	1.09	1.14	0.37	000
32552		A	Remove lung catheter	2.53	2.06	2.06	1.49	1.49	0.42	010

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32553		A	Ins mark thor for rt perq	3.80	11.67	11.67	1.29	1.29	0.64	000
32560		A	Treat pleurodesis w/agent	1.54	4.48	5.23	0.48	0.62	0.28	000
32561		A	Lyse chest fibrin init day	1.39	1.04	1.04	0.43	0.43	0.18	000
32562		A	Lyse chest fibrin subq day	1.24	0.92	0.92	0.39	0.39	0.16	000
32601		A	Thoracoscopy, diagnostic	5.45	NA	NA	2.28	2.30	0.91	000
32602		A	Thoracoscopy, diagnostic	5.95	NA	NA	2.45	2.45	0.98	000
32603		A	Thoracoscopy, diagnostic	7.80	NA	NA	3.00	3.06	1.42	000
32604		A	Thoracoscopy, diagnostic	8.77	NA	NA	3.23	3.41	1.49	000
32605		A	Thoracoscopy, diagnostic	6.92	NA	NA	2.67	2.72	1.17	000
32606		A	Thoracoscopy, diagnostic	8.39	NA	NA	3.25	3.27	1.41	000
32650		A	Thoracoscopy, surgical	10.83	NA	NA	5.95	5.94	1.81	090
32651		A	Thoracoscopy, surgical	18.78	NA	NA	8.77	8.23	3.12	090
32652		A	Thoracoscopy, surgical	29.13	NA	NA	12.58	11.90	4.85	090
32653		A	Thoracoscopy, surgical	18.17	NA	NA	8.34	7.92	2.97	090
32654		A	Thoracoscopy, surgical	20.52	NA	NA	9.21	8.64	3.36	090
32655		A	Thoracoscopy, surgical	16.17	NA	NA	7.93	7.55	2.72	090
32656		A	Thoracoscopy, surgical	13.26	NA	NA	6.81	6.81	2.16	090
32657		A	Thoracoscopy, surgical	12.93	NA	NA	6.78	6.79	2.18	090
32658		A	Thoracoscopy, surgical	11.71	NA	NA	6.03	6.30	1.99	090
32659		A	Thoracoscopy, surgical	11.94	NA	NA	6.35	6.49	2.03	090
32660		A	Thoracoscopy, surgical	17.77	NA	NA	8.02	8.29	3.21	090
32661		A	Thoracoscopy, surgical	13.33	NA	NA	6.52	6.77	2.26	090
32662		A	Thoracoscopy, surgical	14.99	NA	NA	7.49	7.57	2.53	090
32663		A	Thoracoscopy, surgical	24.64	NA	NA	10.44	10.46	4.16	090
32664		A	Thoracoscopy, surgical	14.28	NA	NA	6.81	6.94	2.42	090
32665		A	Thoracoscopy, surgical	21.53	NA	NA	10.84	9.47	3.32	090
32800		A	Repair lung hernia	15.71	NA	NA	6.29	7.23	2.65	090
32810		A	Close chest after drainage	14.95	NA	NA	7.46	7.53	2.52	090
32815		A	Close bronchial fistula	50.03	NA	NA	20.50	18.57	8.59	090
32820		A	Reconstruct injured chest	22.51	NA	NA	10.59	11.09	3.79	090
32850		X	Donor pneumonectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32851		A	Lung transplant, single	41.61	NA	NA	22.64	23.38	6.99	090
32852		A	Lung transplant with bypass	45.48	NA	NA	25.46	26.59	7.58	090
32853		A	Lung transplant, double	50.78	NA	NA	25.50	26.42	8.62	090
32854		A	Lung transplant with bypass	54.74	NA	NA	28.93	29.85	9.19	090
32855		C	Prepare donor lung, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32856		C	Prepare donor lung, double	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32900		A	Removal of rib(s)	23.81	NA	NA	10.88	10.44	3.96	090
32905		A	Revise & repair chest wall	23.29	NA	NA	9.98	10.13	3.93	090

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32906		A	Revise & repair chest wall	29.30	NA	NA	11.80	12.09	4.95	090
3293F		I	Abo rh blood typing docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32940		A	Revision of lung	21.34	NA	NA	9.39	9.36	3.60	090
3294F		I	Grp b strep screening docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32960		A	Therapeutic pneumothorax	1.84	1.86	1.77	0.73	0.74	0.31	000
32997		A	Total lung lavage	7.31	NA	NA	2.11	1.95	0.66	000
32998		A	Perq rf ablate tx, pul tumor	5.68	62.77	67.97	1.81	2.25	0.43	000
32999		C	Chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
33010		A	Drainage of heart sac	2.24	NA	NA	0.71	0.94	0.34	000
33011		A	Repeat drainage of heart sac	2.24	NA	NA	0.75	0.89	0.35	000
33015		A	Incision of heart sac	8.52	NA	NA	4.11	5.08	1.21	090
33020		A	Incision of heart sac	14.95	NA	NA	7.12	6.99	2.53	090
33025		A	Incision of heart sac	13.70	NA	NA	6.47	6.41	2.36	090
33030		A	Partial removal of heart sac	22.39	NA	NA	10.06	9.88	3.83	090
33031		A	Partial removal of heart sac	25.38	NA	NA	10.62	10.56	4.42	090
33050		A	Removal of heart sac lesion	16.97	NA	NA	8.24	8.07	2.86	090
33120		A	Removal of heart lesion	27.45	NA	NA	11.78	11.72	4.74	090
33130		A	Removal of heart lesion	24.17	NA	NA	17.53	12.28	4.36	090
33140		A	Heart revascularize (tmr)	28.34	NA	NA	11.21	11.43	5.13	090
33141		A	Heart tmr w/other procedure	2.54	NA	NA	0.82	1.00	0.44	ZZZ
33202		A	Insert epicard eltrd, open	13.20	NA	NA	6.17	6.38	2.28	090
33203		A	Insert epicard eltrd, endo	13.97	NA	NA	6.07	6.78	2.37	090
33206		A	Insertion of heart pacemaker	7.39	NA	NA	3.76	4.75	1.16	090
33207		A	Insertion of heart pacemaker	8.05	NA	NA	3.78	4.87	1.27	090
33208		A	Insertion of heart pacemaker	8.77	NA	NA	4.01	5.19	1.39	090
33210		A	Insertion of heart electrode	3.30	NA	NA	1.09	1.48	0.51	000
33211		A	Insertion of heart electrode	3.39	NA	NA	1.10	1.42	0.54	000
33212		A	Insertion of pulse generator	5.52	NA	NA	2.72	3.47	0.87	090
33213		A	Insertion of pulse generator	6.37	NA	NA	2.99	3.89	1.01	090
33214		A	Upgrade of pacemaker system	7.84	NA	NA	3.94	4.96	1.23	090
33215		A	Reposition pacing-defib lead	4.92	NA	NA	2.48	3.22	0.77	090
33216		A	Insert 1 electrode pm-defib	5.87	NA	NA	3.23	4.23	0.92	090
33217		A	Insert 2 electrode pm-defib	5.84	NA	NA	3.23	4.17	0.92	090
33218		A	Repair lead pace-defib, one	6.07	NA	NA	3.43	4.43	0.95	090
3321F		I	AJCC cncr 0/IA melan docd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33220		A	Repair lead pace-defib, dual	6.15	NA	NA	3.49	4.46	0.96	090
33222		A	Revise pocket, pacemaker	5.10	NA	NA	3.33	4.12	0.80	090
33223		A	Revise pocket for defib	6.55	NA	NA	3.46	4.54	1.03	090
33224		A	Insert pacing lead & connect	9.04	NA	NA	3.32	4.45	1.45	000

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33225		A	L ventric pacing lead add-on	8.33	NA	NA	2.78	3.84	1.31	ZZZ
33226		A	Reposition l ventric lead	8.68	NA	NA	3.20	4.31	1.39	000
3322F		I	Melan >AJCC stage 0 or IA	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33233		A	Removal of pacemaker system	3.39	NA	NA	2.34	3.06	0.53	090
33234		A	Removal of pacemaker system	7.91	NA	NA	3.91	5.07	1.25	090
33235		A	Removal pacemaker electrode	10.15	NA	NA	5.29	6.77	1.60	090
33236		A	Remove electrode/thoracotomy	12.73	NA	NA	6.97	7.04	2.30	090
33237		A	Remove electrode/thoracotomy	13.84	NA	NA	6.52	7.79	2.34	090
33238		A	Remove electrode/thoracotomy	15.40	NA	NA	8.15	8.18	2.64	090
33240		A	Insert pulse generator	7.64	NA	NA	3.53	4.77	1.20	090
33241		A	Remove pulse generator	3.29	NA	NA	2.09	2.79	0.51	090
33243		A	Remove eltrd/thoracotomy	23.57	NA	NA	10.74	11.44	4.00	090
33244		A	Remove eltrd, transven	13.99	NA	NA	6.69	8.82	2.23	090
33249		A	Eltrd/insert pace-defib	15.17	NA	NA	6.79	9.11	2.38	090
3324F		I	Mri ct scan ord rvwd rqstd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33250		A	Ablate heart dysrhythm focus	25.90	NA	NA	10.98	11.09	4.67	090
33251		A	Ablate heart dysrhythm focus	28.92	NA	NA	12.71	12.22	5.07	090
33254		A	Ablate atria, lmtd	23.71	NA	NA	10.77	10.65	4.28	090
33255		A	Ablate atria w/o bypass, ext	29.04	NA	NA	12.39	12.86	5.25	090
33256		A	Ablate atria w/bypass, exten	34.90	NA	NA	14.26	14.86	6.30	090
33257		A	Ablate atria, lmtd, add-on	9.63	NA	NA	5.18	5.17	1.69	ZZZ
33258		A	Ablate atria, x10sv, add-on	11.00	NA	NA	5.65	5.65	1.92	ZZZ
33259		A	Ablate atria w/bypass add-on	14.14	NA	NA	7.33	7.34	2.48	ZZZ
33261		A	Ablate heart dysrhythm focus	28.92	NA	NA	11.91	11.93	5.23	090
33265		A	Ablate atria, lmtd, endo	23.71	NA	NA	10.66	10.56	4.07	090
33266		A	Ablate atria, x10sv, endo	33.04	NA	NA	13.65	13.72	5.76	090
33282		A	Implant pat-active ht record	4.80	NA	NA	2.95	3.91	0.74	090
33284		A	Remove pat-active ht record	3.14	NA	NA	2.41	3.17	0.48	090
3328F		I	Prfrmnc docd 2 wks b/4 surg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33300		A	Repair of heart wound	44.97	NA	NA	16.81	15.40	7.76	090
33305		A	Repair of heart wound	76.93	NA	NA	26.79	24.54	13.35	090
33310		A	Exploratory heart surgery	20.34	NA	NA	9.33	9.24	3.24	090
33315		A	Exploratory heart surgery	26.17	NA	NA	11.27	11.34	4.55	090
33320		A	Repair major blood vessel(s)	18.54	NA	NA	8.19	8.34	3.11	090
33321		A	Repair major vessel	20.81	NA	NA	9.09	9.17	3.51	090
33322		A	Repair major blood vessel(s)	24.42	NA	NA	10.87	10.79	4.24	090
33330		A	Insert major vessel graft	25.29	NA	NA	12.54	10.83	4.56	090
33332		A	Insert major vessel graft	24.56	NA	NA	10.42	10.70	4.44	090
33335		A	Insert major vessel graft	33.91	NA	NA	14.10	13.78	5.92	090

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33400		A	Repair of aortic valve	41.50	NA	NA	16.26	16.44	7.16	090
33401		A	Valvuloplasty, open	24.63	NA	NA	10.60	12.67	3.86	090
33403		A	Valvuloplasty, w/cp bypass	25.61	NA	NA	11.74	12.36	4.60	090
33404		A	Prepare heart-aorta conduit	31.37	NA	NA	13.11	13.48	5.31	090
33405		A	Replacement of aortic valve	41.32	NA	NA	16.74	17.03	7.18	090
33406		A	Replacement of aortic valve	52.68	NA	NA	20.31	20.17	9.23	090
33410		A	Replacement of aortic valve	46.41	NA	NA	18.39	18.05	8.06	090
33411		A	Replacement of aortic valve	62.07	NA	NA	23.42	22.58	10.81	090
33412		A	Replacement of aortic valve	43.94	NA	NA	17.85	18.53	7.93	090
33413		A	Replacement of aortic valve	59.87	NA	NA	21.47	22.29	10.15	090
33414		A	Repair of aortic valve	39.37	NA	NA	15.01	15.46	7.13	090
33415		A	Revision, subvalvular tissue	37.27	NA	NA	14.60	13.95	6.16	090
33416		A	Revise ventricle muscle	36.56	NA	NA	15.22	14.67	6.35	090
33417		A	Repair of aortic valve	29.33	NA	NA	12.97	13.09	5.09	090
33420		A	Revision of mitral valve	25.79	NA	NA	11.87	10.18	2.56	090
33422		A	Revision of mitral valve	29.73	NA	NA	12.44	12.83	5.37	090
33425		A	Repair of mitral valve	49.96	NA	NA	19.26	18.18	8.68	090
33426		A	Repair of mitral valve	43.28	NA	NA	17.45	17.41	7.52	090
33427		A	Repair of mitral valve	44.83	NA	NA	17.32	17.76	7.79	090
33430		A	Replacement of mitral valve	50.93	NA	NA	20.50	19.93	8.86	090
33460		A	Revision of tricuspid valve	44.70	NA	NA	29.01	19.06	8.09	090
33463		A	Valvuloplasty, tricuspid	57.08	NA	NA	21.48	20.04	9.98	090
33464		A	Valvuloplasty, tricuspid	44.62	NA	NA	17.92	16.85	7.76	090
33465		A	Replace tricuspid valve	50.72	NA	NA	19.39	18.21	8.89	090
33468		A	Revision of tricuspid valve	32.94	NA	NA	13.19	14.42	5.95	090
33470		A	Revision of pulmonary valve	21.54	NA	NA	9.35	9.70	3.62	090
33471		A	Valvotomy, pulmonary valve	22.96	NA	NA	10.93	10.53	1.14	090
33472		A	Revision of pulmonary valve	23.06	NA	NA	10.48	10.55	1.15	090
33474		A	Revision of pulmonary valve	39.40	NA	NA	15.00	13.86	6.66	090
33475		A	Replacement, pulmonary valve	42.40	NA	NA	16.50	16.36	7.66	090
33476		A	Revision of heart chamber	26.57	NA	NA	11.65	11.29	4.79	090
33478		A	Revision of heart chamber	27.54	NA	NA	11.95	12.13	4.96	090
33496		A	Repair, prosth valve clot	29.84	NA	NA	12.73	12.65	5.05	090
33500		A	Repair heart vessel fistula	27.94	NA	NA	11.60	11.83	5.05	090
33501		A	Repair heart vessel fistula	19.51	NA	NA	8.75	8.68	3.52	090
33502		A	Coronary artery correction	21.85	NA	NA	10.19	10.24	3.93	090
33503		A	Coronary artery graft	22.51	NA	NA	9.90	12.19	3.52	090
33504		A	Coronary artery graft	25.46	NA	NA	11.35	11.23	4.59	090
33505		A	Repair artery w/tunnel	38.40	NA	NA	13.16	13.31	6.96	090

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33506		A	Repair artery, translocation	37.85	NA	NA	13.49	14.06	6.42	090
33507		A	Repair art, intramural	31.40	NA	NA	11.67	12.38	5.33	090
33508		A	Endoscopic vein harvest	0.31	NA	NA	0.10	0.10	0.05	ZZZ
33510		A	CABG, vein, single	34.98	NA	NA	14.52	14.74	6.08	090
33511		A	CABG, vein, two	38.45	NA	NA	15.80	15.99	6.69	090
33512		A	CABG, vein, three	43.98	NA	NA	17.49	17.63	7.66	090
33513		A	CABG, vein, four	45.37	NA	NA	17.87	17.61	7.93	090
33514		A	CABG, vein, five	48.08	NA	NA	18.79	18.82	8.35	090
33516		A	Cabg, vein, six or more	49.76	NA	NA	18.83	19.48	9.00	090
33517		A	CABG, artery-vein, single	3.61	NA	NA	1.17	1.14	0.62	ZZZ
33518		A	CABG, artery-vein, two	7.93	NA	NA	2.57	2.44	1.37	ZZZ
33519		A	CABG, artery-vein, three	10.49	NA	NA	3.41	3.28	1.84	ZZZ
3351F		I	Neg scrn dep symp by deptool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33521		A	CABG, artery-vein, four	12.59	NA	NA	4.10	3.99	2.20	ZZZ
33522		A	CABG, artery-vein, five	14.14	NA	NA	4.62	4.56	2.48	ZZZ
33523		A	Cabg, art-vein, six or more	16.08	NA	NA	5.19	5.18	2.81	ZZZ
3352F		I	No sig dep symp by dep tool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33530		A	Coronary artery, bypass/reop	10.13	NA	NA	3.26	3.09	1.78	ZZZ
33533		A	CABG, arterial, single	33.75	NA	NA	13.92	14.41	5.87	090
33534		A	CABG, arterial, two	39.88	NA	NA	16.23	16.56	6.94	090
33535		A	CABG, arterial, three	44.75	NA	NA	17.82	18.06	7.78	090
33536		A	Cabg, arterial, four or more	48.43	NA	NA	19.20	18.96	8.47	090
3353F		I	Mild-mod dep symp by deptool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33542		A	Removal of heart lesion	48.21	NA	NA	18.61	17.56	8.42	090
33545		A	Repair of heart damage	57.06	NA	NA	21.07	20.31	9.90	090
33548		A	Restore/remodel, ventricle	54.14	NA	NA	21.34	21.37	9.47	090
3354F		I	Clin sig dep sym by dep tool	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33572		A	Open coronary endarterectomy	4.44	NA	NA	1.43	1.46	0.77	ZZZ
33600		A	Closure of valve	30.31	NA	NA	12.60	12.74	5.13	090
33602		A	Closure of valve	29.34	NA	NA	14.58	12.63	4.51	090
33606		A	Anastomosis/artery-aorta	31.53	NA	NA	15.27	13.80	4.85	090
33608		A	Repair anomaly w/conduit	31.88	NA	NA	13.08	13.79	5.39	090
33610		A	Repair by enlargement	31.40	NA	NA	12.93	13.30	5.31	090
33611		A	Repair double ventricle	35.57	NA	NA	13.47	13.86	6.43	090
33612		A	Repair double ventricle	36.57	NA	NA	13.70	13.98	5.77	090
33615		A	Repair, modified fontan	35.89	NA	NA	13.98	14.99	6.07	090
33617		A	Repair single ventricle	39.09	NA	NA	14.95	15.07	6.61	090
33619		A	Repair single ventricle	48.76	NA	NA	19.33	18.29	8.25	090
33641		A	Repair heart septum defect	29.58	NA	NA	12.28	11.62	5.15	090

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33645		A	Revision of heart veins	28.10	NA	NA	11.47	11.82	5.08	090
33647		A	Repair heart septum defects	29.53	NA	NA	21.24	15.55	5.33	090
33660		A	Repair of heart defects	31.83	NA	NA	12.32	12.47	5.76	090
33665		A	Repair of heart defects	34.85	NA	NA	23.26	16.14	6.30	090
33670		A	Repair of heart chambers	36.63	NA	NA	12.96	13.35	6.63	090
33675		A	Close mult vsd	35.95	NA	NA	13.36	13.77	6.50	090
33676		A	Close mult vsd w/resection	36.95	NA	NA	15.51	14.95	1.87	090
33677		A	Cl mult vsd w/rem pul band	38.45	NA	NA	16.06	15.48	1.94	090
33681		A	Repair heart septum defect	32.34	NA	NA	14.37	14.11	5.63	090
33684		A	Repair heart septum defect	34.37	NA	NA	22.60	15.85	6.22	090
33688		A	Repair heart septum defect	34.75	NA	NA	12.61	12.49	6.29	090
33690		A	Reinforce pulmonary artery	20.36	NA	NA	9.60	9.50	3.43	090
33692		A	Repair of heart defects	31.54	NA	NA	13.61	13.13	1.58	090
33694		A	Repair of heart defects	35.57	NA	NA	13.21	14.07	6.43	090
33697		A	Repair of heart defects	37.57	NA	NA	14.03	16.51	5.93	090
33702		A	Repair of heart defects	27.24	NA	NA	11.59	11.57	4.91	090
33710		A	Repair of heart defects	30.41	NA	NA	12.33	15.59	5.15	090
33720		A	Repair of heart defect	27.26	NA	NA	11.38	11.84	4.61	090
33722		A	Repair of heart defect	29.21	NA	NA	11.41	11.49	5.27	090
33724		A	Repair venous anomaly	27.63	NA	NA	10.85	11.78	4.68	090
33726		A	Repair pul venous stenosis	37.12	NA	NA	13.99	14.61	6.71	090
33730		A	Repair heart-vein defect(s)	36.14	NA	NA	14.23	13.47	6.53	090
33732		A	Repair heart-vein defect	28.96	NA	NA	12.43	12.65	5.23	090
33735		A	Revision of heart chamber	22.20	NA	NA	10.15	10.18	3.99	090
33736		A	Revision of heart chamber	24.32	NA	NA	11.00	11.11	4.38	090
33737		A	Revision of heart chamber	22.47	NA	NA	9.93	10.24	3.79	090
33750		A	Major vessel shunt	22.22	NA	NA	14.69	12.94	5.74	090
33755		A	Major vessel shunt	22.60	NA	NA	9.70	9.94	3.55	090
33762		A	Major vessel shunt	22.60	NA	NA	10.34	10.12	1.12	090
33764		A	Major vessel shunt & graft	22.60	NA	NA	12.10	10.24	3.47	090
33766		A	Major vessel shunt	23.57	NA	NA	9.47	11.12	3.70	090
33767		A	Major vessel shunt	25.30	NA	NA	10.23	10.22	4.56	090
33768		A	Cavopulmonary shunting	8.00	NA	NA	2.92	2.79	0.40	ZZZ
33770		A	Repair great vessels defect	39.07	NA	NA	16.55	15.20	6.62	090
33771		A	Repair great vessels defect	40.63	NA	NA	16.10	15.00	2.05	090
33774		A	Repair great vessels defect	31.73	NA	NA	13.46	13.78	5.72	090
33775		A	Repair great vessels defect	32.99	NA	NA	14.75	14.52	1.66	090
33776		A	Repair great vessels defect	34.75	NA	NA	15.68	15.41	1.75	090
33777		A	Repair great vessels defect	34.17	NA	NA	14.71	14.57	1.72	090

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33778		A	Repair great vessels defect	42.75	NA	NA	18.07	17.46	2.16	090
33779		A	Repair great vessels defect	43.23	NA	NA	17.29	16.50	2.18	090
33780		A	Repair great vessels defect	43.90	NA	NA	28.12	20.20	2.22	090
33781		A	Repair great vessels defect	43.21	NA	NA	17.04	15.91	2.18	090
33782		A	Nikaidoh proc	60.08	NA	NA	20.65	20.65	10.19	090
33783		A	Nikaidoh proc w/ostia implt	65.08	NA	NA	22.16	22.16	11.04	090
33786		A	Repair arterial trunk	41.87	NA	NA	17.20	16.40	2.11	090
33788		A	Revision of pulmonary artery	27.42	NA	NA	12.10	11.83	1.37	090
33800		A	Aortic suspension	17.28	NA	NA	7.52	7.33	3.12	090
33802		A	Repair vessel defect	18.37	NA	NA	8.69	8.46	3.31	090
33803		A	Repair vessel defect	20.31	NA	NA	8.42	8.30	3.66	090
33813		A	Repair septal defect	21.36	NA	NA	9.60	11.00	3.60	090
33814		A	Repair septal defect	26.57	NA	NA	11.69	11.87	4.79	090
33820		A	Revise major vessel	16.69	NA	NA	7.65	7.94	3.01	090
33822		A	Revise major vessel	17.71	NA	NA	8.46	8.43	0.88	090
33824		A	Revise major vessel	20.23	NA	NA	10.34	9.67	3.41	090
33840		A	Remove aorta constriction	21.34	NA	NA	9.09	9.11	3.84	090
33845		A	Remove aorta constriction	22.93	NA	NA	10.57	11.51	4.12	090
33851		A	Remove aorta constriction	21.98	NA	NA	9.78	9.76	3.96	090
33852		A	Repair septal defect	24.41	NA	NA	17.89	12.68	4.40	090
33853		A	Repair septal defect	32.51	NA	NA	22.99	17.20	5.87	090
33860		A	Ascending aortic graft	59.46	NA	NA	22.07	21.27	10.31	090
33861		A	Ascending aortic graft	44.07	NA	NA	17.28	17.42	7.68	090
33863		A	Ascending aortic graft	58.79	NA	NA	21.12	21.04	10.19	090
33864		A	Ascending aortic graft	60.08	NA	NA	21.78	21.93	10.37	090
33870		A	Transverse aortic arch graft	46.06	NA	NA	17.74	18.07	7.94	090
33875		A	Thoracic aortic graft	35.78	NA	NA	13.88	14.15	6.18	090
33877		A	Thoracoabdominal graft	69.03	NA	NA	23.33	22.00	11.82	090
33880		A	Endovasc taa repr incl subcl	34.58	NA	NA	12.05	12.46	5.59	090
33881		A	Endovasc taa repr w/o subcl	29.58	NA	NA	10.47	10.84	4.77	090
33883		A	Insert endovasc prosth, taa	21.09	NA	NA	7.96	8.21	3.38	090
33884		A	Endovasc prosth, taa, add-on	8.20	NA	NA	2.41	2.42	1.32	ZZZ
33886		A	Endovasc prosth, delayed	18.09	NA	NA	6.38	6.97	3.10	090
33889		A	Artery transpose/endovas taa	15.92	NA	NA	4.28	4.53	2.74	000
33891		A	Car-car bp grft/endovas taa	20.00	NA	NA	5.37	5.60	3.44	000
33910		A	Remove lung artery emboli	29.71	NA	NA	12.56	12.50	5.37	090
33915		A	Remove lung artery emboli	24.95	NA	NA	9.69	9.76	3.92	090
33916		A	Surgery of great vessel	28.42	NA	NA	11.53	13.31	5.14	090
33917		A	Repair pulmonary artery	25.30	NA	NA	11.09	12.39	4.27	090

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33920		A	Repair pulmonary atresia	32.74	NA	NA	12.47	13.03	5.91	090
33922		A	Transect pulmonary artery	24.22	NA	NA	10.66	10.71	4.37	090
33924		A	Remove pulmonary shunt	5.49	NA	NA	1.66	1.72	0.93	ZZZ
33925		A	Rpr pul art unifocal w/o cpb	31.30	NA	NA	11.64	12.73	5.31	090
33926		A	Repr pul art, unifocal w/cpb	44.73	NA	NA	18.88	15.34	8.10	090
33930		X	Removal of donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33933		C	Prepare donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33935		R	Transplantation, heart/lung	62.01	NA	NA	24.73	25.38	11.18	090
33940		X	Removal of donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33944		C	Prepare donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33945		R	Transplantation of heart	89.50	NA	NA	32.81	31.19	15.42	090
33960		A	External circulation assist	19.33	NA	NA	6.07	5.94	2.77	000
33961		A	External circulation assist	10.91	NA	NA	3.29	3.49	1.20	ZZZ
33967		A	Insert ia percut device	4.84	NA	NA	1.60	2.17	0.77	000
33968		A	Remove aortic assist device	0.64	NA	NA	0.22	0.26	0.10	000
33970		A	Aortic circulation assist	6.74	NA	NA	2.18	2.55	1.13	000
33971		A	Aortic circulation assist	11.99	NA	NA	5.89	6.31	2.03	090
33973		A	Insert balloon device	9.75	NA	NA	3.12	3.73	1.65	000
33974		A	Remove intra-aortic balloon	15.03	NA	NA	7.35	8.11	2.71	090
33975		A	Implant ventricular device	20.97	NA	NA	6.72	6.93	3.61	XXX
33976		A	Implant ventricular device	22.97	NA	NA	7.09	7.93	4.17	XXX
33977		A	Remove ventricular device	20.28	NA	NA	10.30	10.40	3.45	090
33978		A	Remove ventricular device	22.72	NA	NA	11.03	10.95	4.07	090
33979		A	Insert intracorporeal device	45.93	NA	NA	14.31	15.00	7.96	XXX
33980		A	Remove intracorporeal device	65.20	NA	NA	26.17	26.25	11.35	090
33981		C	Replace vad pump ext	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33982		C	Replace vad intra w/o bp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33983		C	Replace vad intra w/bp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33999		C	Cardiac surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
34001		A	Removal of artery clot	17.88	NA	NA	7.63	7.15	2.93	090
34051		A	Removal of artery clot	16.99	NA	NA	8.05	7.81	3.07	090
34101		A	Removal of artery clot	10.93	NA	NA	5.02	4.85	1.79	090
34111		A	Removal of arm artery clot	10.93	NA	NA	5.08	4.86	1.77	090
34151		A	Removal of artery clot	26.52	NA	NA	10.39	9.75	4.31	090
34201		A	Removal of artery clot	19.48	NA	NA	7.78	6.93	3.23	090
34203		A	Removal of leg artery clot	17.86	NA	NA	7.46	7.26	2.96	090
34401		A	Removal of vein clot	26.52	NA	NA	10.92	11.03	4.08	090
34421		A	Removal of vein clot	13.37	NA	NA	5.98	5.81	2.13	090
34451		A	Removal of vein clot	28.52	NA	NA	9.30	10.13	4.89	090

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34471		A	Removal of vein clot	21.11	NA	NA	10.38	7.98	3.25	090
34490		A	Removal of vein clot	10.91	NA	NA	5.18	4.97	1.76	090
34501		A	Repair valve, femoral vein	16.85	NA	NA	6.72	7.33	2.88	090
34502		A	Reconstruct vena cava	28.07	NA	NA	11.51	11.52	4.24	090
3450F		I	Dyspnea scrnd, no-mild dysp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34510		A	Transposition of vein valve	19.91	NA	NA	9.96	8.47	3.06	090
3451F		I	Dyspnea scrnd mod-high dysp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34520		A	Cross-over vein graft	19.18	NA	NA	6.89	7.40	3.28	090
3452F		I	Dyspnea not screened	0.00	0.00	0.00	0.00	0.00	0.00	XXX
34530		A	Leg vein fusion	17.93	NA	NA	9.79	8.12	2.75	090
34800		A	Endovas aaa repr w/sm tube	21.54	NA	NA	7.97	8.29	3.31	090
34802		A	Endovas aaa repr w/2-p part	23.79	NA	NA	8.90	9.06	3.68	090
34803		A	Endovas aaa repr w/3-p part	24.82	NA	NA	8.98	9.06	3.85	090
34804		A	Endovas aaa repr w/1-p part	23.79	NA	NA	8.93	9.07	3.71	090
34805		A	Endovas aaa repr w/long tube	22.67	NA	NA	8.29	8.32	3.63	090
34806		A	Aneurysm press sensor add-on	2.06	NA	NA	0.61	0.64	0.33	ZZZ
34808		A	Endovas iliac a device addon	4.12	NA	NA	1.21	1.21	0.66	ZZZ
34812		A	Xpose for endoprosth, femorl	6.74	NA	NA	2.07	1.98	1.12	000
34813		A	Femoral endovas graft add-on	4.79	NA	NA	1.42	1.37	0.80	ZZZ
34820		A	Xpose for endoprosth, iliac	9.74	NA	NA	2.90	2.88	1.58	000
34825		A	Endovasc extend prosth, init	12.80	NA	NA	5.52	5.66	1.99	090
34826		A	Endovasc exten prosth, addl	4.12	NA	NA	1.26	1.27	0.64	ZZZ
34830		A	Open aortic tube prosth repr	35.23	NA	NA	11.19	11.90	6.04	090
34831		A	Open aortoiliac prosth repr	37.98	NA	NA	11.93	12.08	6.51	090
34832		A	Open aortofemor prosth repr	37.98	NA	NA	11.93	12.67	6.51	090
34833		A	Xpose for endoprosth, iliac	11.98	NA	NA	3.85	3.84	2.03	000
34834		A	Xpose, endoprosth, brachial	5.34	NA	NA	1.81	1.83	0.89	000
34900		A	Endovasc iliac repr w/graft	16.85	NA	NA	6.70	6.86	2.59	090
3491F		I	HIV unsure baby of HIV+moms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3497F		I	CD4+ cell percentage <15%	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3498F		I	CD4+ cell percentage >=15%	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35001		A	Repair defect of artery	20.81	NA	NA	8.82	8.68	3.46	090
35002		A	Repair artery rupture, neck	22.23	NA	NA	10.90	9.34	3.42	090
35005		A	Repair defect of artery	19.29	NA	NA	6.90	7.95	3.30	090
35011		A	Repair defect of artery	18.58	NA	NA	7.62	7.28	3.05	090
35013		A	Repair artery rupture, arm	23.23	NA	NA	9.40	8.94	3.80	090
35021		A	Repair defect of artery	22.17	NA	NA	9.47	9.36	3.75	090
35022		A	Repair artery rupture, chest	25.70	NA	NA	10.53	10.07	4.35	090

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35045		A	Repair defect of arm artery	18.01	NA	NA	7.89	7.26	2.89	090
35081		A	Repair defect of artery	33.53	NA	NA	12.72	11.90	5.60	090
35082		A	Repair artery rupture, aorta	42.09	NA	NA	15.53	14.61	6.98	090
35091		A	Repair defect of artery	35.35	NA	NA	12.09	11.74	5.94	090
35092		A	Repair artery rupture, aorta	50.97	NA	NA	17.81	16.74	8.53	090
35102		A	Repair defect of artery	36.53	NA	NA	13.51	12.64	6.09	090
35103		A	Repair artery rupture, groin	43.62	NA	NA	15.53	14.77	7.22	090
3510F		I	Doc tb scrng-rslts interpd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35111		A	Repair defect of artery	26.28	NA	NA	12.29	10.31	4.04	090
35112		A	Repair artery rupture,spleen	32.57	NA	NA	14.74	12.35	5.02	090
35121		A	Repair defect of artery	31.52	NA	NA	11.77	11.17	5.25	090
35122		A	Repair artery rupture, belly	37.89	NA	NA	16.70	14.12	5.84	090
35131		A	Repair defect of artery	26.40	NA	NA	10.34	9.93	4.41	090
35132		A	Repair artery rupture, groin	32.57	NA	NA	12.08	11.52	5.39	090
3513F		I	Hep B scrng docd as done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35141		A	Repair defect of artery	20.91	NA	NA	8.25	7.96	3.48	090
35142		A	Repair artery rupture, thigh	25.16	NA	NA	9.75	9.46	4.19	090
3514F		I	Hep C scrng docd as done	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35151		A	Repair defect of artery	23.72	NA	NA	9.19	8.87	3.95	090
35152		A	Repair artery rupture, knee	27.66	NA	NA	9.15	9.91	4.74	090
3515F		I	Pt has docd immun to hep C	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35180		A	Repair blood vessel lesion	15.10	NA	NA	6.74	7.18	2.59	090
35182		A	Repair blood vessel lesion	31.71	NA	NA	15.32	13.36	4.88	090
35184		A	Repair blood vessel lesion	18.82	NA	NA	9.35	7.88	2.90	090
35188		A	Repair blood vessel lesion	15.16	NA	NA	8.30	7.21	2.33	090
35189		A	Repair blood vessel lesion	29.98	NA	NA	11.78	11.18	5.42	090
35190		A	Repair blood vessel lesion	13.42	NA	NA	6.28	5.95	2.20	090
35201		A	Repair blood vessel lesion	16.93	NA	NA	7.78	7.31	2.71	090
35206		A	Repair blood vessel lesion	13.84	NA	NA	6.38	6.00	2.20	090
35207		A	Repair blood vessel lesion	10.94	NA	NA	8.14	7.38	1.40	090
35211		A	Repair blood vessel lesion	24.58	NA	NA	10.85	10.56	4.28	090
35216		A	Repair blood vessel lesion	36.61	NA	NA	15.33	13.83	6.23	090
35221		A	Repair blood vessel lesion	26.62	NA	NA	10.65	9.69	4.23	090
35226		A	Repair blood vessel lesion	15.30	NA	NA	6.46	6.48	2.55	090
35231		A	Repair blood vessel lesion	21.16	NA	NA	10.52	9.41	3.01	090
35236		A	Repair blood vessel lesion	18.02	NA	NA	7.72	7.29	2.88	090
35241		A	Repair blood vessel lesion	25.58	NA	NA	11.17	10.96	4.57	090
35246		A	Repair blood vessel lesion	28.23	NA	NA	9.41	10.88	4.85	090
35251		A	Repair blood vessel lesion	31.91	NA	NA	12.27	11.14	5.07	090

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35256		A	Repair blood vessel lesion	19.06	NA	NA	7.70	7.43	3.15	090
35261		A	Repair blood vessel lesion	18.96	NA	NA	8.51	7.95	3.35	090
35266		A	Repair blood vessel lesion	15.83	NA	NA	6.80	6.48	2.62	090
35271		A	Repair blood vessel lesion	24.58	NA	NA	10.65	10.49	4.44	090
35276		A	Repair blood vessel lesion	25.83	NA	NA	10.81	10.82	4.37	090
35281		A	Repair blood vessel lesion	30.06	NA	NA	11.69	11.00	4.90	090
35286		A	Repair blood vessel lesion	17.19	NA	NA	7.44	7.21	2.85	090
35301		A	Rechanneling of artery	19.61	NA	NA	8.01	7.68	3.30	090
35302		A	Rechanneling of artery	21.35	NA	NA	8.34	7.67	3.55	090
35303		A	Rechanneling of artery	23.60	NA	NA	9.07	8.34	3.92	090
35304		A	Rechanneling of artery	24.60	NA	NA	9.33	8.59	4.07	090
35305		A	Rechanneling of artery	23.60	NA	NA	9.04	8.30	3.92	090
35306		A	Rechanneling of artery	9.25	NA	NA	2.49	2.47	1.59	ZZZ
35311		A	Rechanneling of artery	28.60	NA	NA	10.62	10.60	4.84	090
35321		A	Rechanneling of artery	16.59	NA	NA	7.05	6.68	2.72	090
35331		A	Rechanneling of artery	27.72	NA	NA	10.70	10.46	4.65	090
35341		A	Rechanneling of artery	26.21	NA	NA	9.77	9.59	4.38	090
35351		A	Rechanneling of artery	24.61	NA	NA	9.36	8.86	4.08	090
35355		A	Rechanneling of artery	19.86	NA	NA	7.71	7.36	3.30	090
35361		A	Rechanneling of artery	30.24	NA	NA	9.85	10.53	5.19	090
35363		A	Rechanneling of artery	32.35	NA	NA	12.29	12.40	5.48	090
35371		A	Rechanneling of artery	15.31	NA	NA	6.40	6.14	2.54	090
35372		A	Rechanneling of artery	18.58	NA	NA	7.39	7.09	3.08	090
35390		A	Reoperation, carotid add-on	3.19	NA	NA	0.99	0.96	0.54	ZZZ
35400		A	Angioscopy	3.00	NA	NA	0.90	0.91	0.50	ZZZ
35450		A	Repair arterial blockage	10.05	NA	NA	3.29	3.34	1.63	000
35452		A	Repair arterial blockage	6.90	NA	NA	2.42	2.38	1.14	000
35454		A	Repair arterial blockage	6.03	NA	NA	2.09	2.07	0.98	000
35456		A	Repair arterial blockage	7.34	NA	NA	2.55	2.49	1.20	000
35458		A	Repair arterial blockage	9.48	NA	NA	3.33	3.19	1.54	000
35459		A	Repair arterial blockage	8.62	NA	NA	2.96	2.95	1.42	000
35460		A	Repair venous blockage	6.03	NA	NA	2.23	2.07	0.96	000
35470		A	Repair arterial blockage	8.62	52.72	64.41	2.90	3.43	1.26	000
35471		A	Repair arterial blockage	10.05	52.64	69.04	3.42	4.36	1.46	000
35472		A	Repair arterial blockage	6.90	41.42	49.13	2.39	2.73	1.04	000
35473		A	Repair arterial blockage	6.03	40.09	47.50	2.11	2.48	0.89	000
35474		A	Repair arterial blockage	7.35	52.14	63.61	2.52	2.97	1.07	000
35475		R	Repair arterial blockage	9.48	46.82	49.81	3.21	3.56	1.09	000
35476		A	Repair venous blockage	6.03	36.14	38.75	2.12	2.34	0.60	000

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35480		A	Atherectomy, open	11.06	NA	NA	3.18	3.45	1.91	000
35481		A	Atherectomy, open	7.60	NA	NA	2.70	2.77	1.28	000
35482		A	Atherectomy, open	6.64	NA	NA	1.99	2.38	1.14	000
35483		A	Atherectomy, open	8.09	NA	NA	2.96	2.92	1.31	000
35484		A	Atherectomy, open	10.42	NA	NA	3.00	3.28	1.80	000
35485		A	Atherectomy, open	9.48	NA	NA	3.43	3.30	1.55	000
35490		A	Atherectomy, percutaneous	11.06	NA	NA	4.17	5.09	1.74	000
35491		A	Atherectomy, percutaneous	7.60	NA	NA	3.03	3.20	1.30	000
35492		A	Atherectomy, percutaneous	6.64	NA	NA	2.65	3.20	1.04	000
35493		A	Atherectomy, percutaneous	8.09	NA	NA	3.14	3.86	1.24	000
35494		A	Atherectomy, percutaneous	10.42	NA	NA	3.94	4.81	1.58	000
35495		A	Atherectomy, percutaneous	9.48	NA	NA	3.59	4.35	1.48	000
35500		A	Harvest vein for bypass	6.44	NA	NA	2.05	1.89	1.07	ZZZ
35501		A	Artery bypass graft	29.09	NA	NA	12.43	11.59	4.84	090
35506		A	Artery bypass graft	25.33	NA	NA	9.62	9.50	4.35	090
35508		A	Artery bypass graft	26.09	NA	NA	10.89	10.21	4.71	090
35509		A	Artery bypass graft	28.09	NA	NA	10.78	10.76	4.82	090
3550F		I	Low rsk thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35510		A	Artery bypass graft	24.39	NA	NA	8.04	8.75	4.19	090
35511		A	Artery bypass graft	22.20	NA	NA	10.35	9.04	3.80	090
35512		A	Artery bypass graft	23.89	NA	NA	7.91	8.43	4.09	090
35515		A	Artery bypass graft	26.09	NA	NA	10.68	9.15	4.48	090
35516		A	Artery bypass graft	24.21	NA	NA	7.96	7.78	4.14	090
35518		A	Artery bypass graft	22.65	NA	NA	7.46	8.34	3.88	090
3551F		I	Intrmed rsk thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35521		A	Artery bypass graft	24.13	NA	NA	8.21	8.70	4.13	090
35522		A	Artery bypass graft	23.15	NA	NA	9.15	8.72	3.96	090
35523		A	Artery bypass graft	24.13	NA	NA	9.86	9.65	3.96	090
35525		A	Artery bypass graft	21.69	NA	NA	8.59	8.15	3.47	090
35526		A	Artery bypass graft	31.55	NA	NA	12.30	11.99	5.71	090
3552F		I	Hgh risk for thromboembolism	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35531		A	Artery bypass graft	39.11	NA	NA	14.30	13.59	6.44	090
35533		A	Artery bypass graft	29.92	NA	NA	13.76	11.59	5.14	090
35535		A	Artery bypass graft	38.13	NA	NA	14.31	13.99	1.92	090
35536		A	Artery bypass graft	33.73	NA	NA	10.79	11.25	5.79	090
35537		A	Artery bypass graft	41.88	NA	NA	13.05	13.82	7.19	090
35538		A	Artery bypass graft	47.03	NA	NA	14.46	15.51	8.06	090
35539		A	Artery bypass graft	44.11	NA	NA	13.65	13.95	7.57	090
35540		A	Artery bypass graft	49.33	NA	NA	17.72	16.29	8.20	090

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35548		A	Artery bypass graft	22.68	NA	NA	7.81	8.40	3.88	090
35549		A	Artery bypass graft	24.45	NA	NA	8.29	9.19	3.76	090
35551		A	Artery bypass graft	27.83	NA	NA	12.97	11.39	4.29	090
35556		A	Artery bypass graft	26.75	NA	NA	10.45	9.69	4.44	090
35558		A	Artery bypass graft	23.13	NA	NA	9.38	8.93	3.83	090
3555F		I	Pt inr measurement performed	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35560		A	Artery bypass graft	34.03	NA	NA	12.62	12.20	5.84	090
35563		A	Artery bypass graft	26.12	NA	NA	12.36	10.09	4.48	090
35565		A	Artery bypass graft	25.13	NA	NA	9.72	9.40	4.13	090
35566		A	Artery bypass graft	32.35	NA	NA	11.94	11.21	5.41	090
35570		A	Artery bypass graft	29.15	NA	NA	11.54	11.28	1.46	090
35571		A	Artery bypass graft	25.52	NA	NA	9.70	9.43	4.25	090
35572		A	Harvest femoropopliteal vein	6.81	NA	NA	2.17	2.18	1.15	ZZZ
35583		A	Vein bypass graft	27.75	NA	NA	10.65	9.89	4.59	090
35585		A	Vein bypass graft	32.35	NA	NA	12.25	11.46	5.36	090
35587		A	Vein bypass graft	26.21	NA	NA	10.03	9.82	4.36	090
35600		A	Harvest art for cabg add-on	4.94	NA	NA	1.67	1.68	0.86	ZZZ
35601		A	Artery bypass graft	27.09	NA	NA	12.09	10.75	4.59	090
35606		A	Artery bypass graft	22.46	NA	NA	8.54	8.29	3.78	090
35612		A	Artery bypass graft	16.82	NA	NA	6.23	7.00	2.88	090
35616		A	Artery bypass graft	21.82	NA	NA	10.21	8.38	3.36	090
35621		A	Artery bypass graft	21.03	NA	NA	8.14	7.80	3.51	090
35623		A	Bypass graft, not vein	25.92	NA	NA	8.69	9.24	4.44	090
35626		A	Artery bypass graft	29.14	NA	NA	11.40	11.35	5.06	090
35631		A	Artery bypass graft	36.03	NA	NA	12.44	12.19	6.09	090
35632		A	Artery bypass graft	36.13	NA	NA	13.67	13.36	1.82	090
35633		A	Artery bypass graft	39.11	NA	NA	14.62	14.30	1.97	090
35634		A	Artery bypass graft	35.33	NA	NA	13.41	13.12	1.78	090
35636		A	Artery bypass graft	31.75	NA	NA	10.26	10.97	5.45	090
35637		A	Artery bypass graft	33.05	NA	NA	12.56	11.58	5.53	090
35638		A	Artery bypass graft	33.60	NA	NA	12.65	11.92	5.66	090
35642		A	Artery bypass graft	18.94	NA	NA	7.09	7.93	3.24	090
35645		A	Artery bypass graft	18.43	NA	NA	7.83	7.26	3.32	090
35646		A	Artery bypass graft	32.98	NA	NA	12.42	11.93	5.50	090
35647		A	Artery bypass graft	29.73	NA	NA	11.16	10.88	4.98	090
35650		A	Artery bypass graft	20.16	NA	NA	8.07	7.69	3.32	090
35651		A	Artery bypass graft	26.08	NA	NA	12.33	10.55	4.01	090
35654		A	Artery bypass graft	26.28	NA	NA	10.03	9.63	4.38	090
35656		A	Artery bypass graft	20.47	NA	NA	8.20	7.83	3.40	090

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35661		A	Artery bypass graft	20.35	NA	NA	8.46	8.10	3.37	090
35663		A	Artery bypass graft	23.93	NA	NA	9.30	9.01	3.94	090
35665		A	Artery bypass graft	22.35	NA	NA	8.76	8.46	3.69	090
35666		A	Artery bypass graft	23.66	NA	NA	10.01	9.64	3.93	090
35671		A	Artery bypass graft	20.77	NA	NA	8.95	8.60	3.44	090
35681		A	Composite bypass graft	1.60	NA	NA	0.50	0.48	0.27	ZZZ
35682		A	Composite bypass graft	7.19	NA	NA	2.12	2.06	1.20	ZZZ
35683		A	Composite bypass graft	8.49	NA	NA	2.28	2.38	1.46	ZZZ
35685		A	Bypass graft patency/patch	4.04	NA	NA	1.21	1.16	0.68	ZZZ
35686		A	Bypass graft/av fist patency	3.34	NA	NA	1.01	1.01	0.55	ZZZ
35691		A	Arterial transposition	18.41	NA	NA	6.51	7.06	3.15	090
35693		A	Arterial transposition	15.73	NA	NA	6.30	6.91	2.70	090
35694		A	Arterial transposition	19.28	NA	NA	6.74	7.10	3.30	090
35695		A	Arterial transposition	20.06	NA	NA	6.95	7.42	3.44	090
35697		A	Reimplant artery each	3.00	NA	NA	0.90	0.88	0.50	ZZZ
35700		A	Reoperation, bypass graft	3.08	NA	NA	0.94	0.91	0.51	ZZZ
35701		A	Exploration, carotid artery	9.19	NA	NA	5.42	4.96	1.28	090
35721		A	Exploration, femoral artery	7.72	NA	NA	4.15	4.12	1.25	090
3572F		I	Pt consid poss risk fx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
3573F		I	Pt not consid poss risk fx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
35741		A	Exploration popliteal artery	8.69	NA	NA	4.66	4.37	1.40	090
35761		A	Exploration of artery/vein	5.93	NA	NA	4.11	3.84	0.92	090
35800		A	Explore neck vessels	8.07	NA	NA	4.74	4.44	1.22	090
35820		A	Explore chest vessels	36.89	NA	NA	14.04	12.87	6.38	090
35840		A	Explore abdominal vessels	10.96	NA	NA	5.86	5.33	1.72	090
35860		A	Explore limb vessels	6.80	NA	NA	3.94	3.77	1.10	090
35870		A	Repair vessel graft defect	24.50	NA	NA	8.30	8.77	4.20	090
35875		A	Removal of clot in graft	10.72	NA	NA	5.00	4.79	1.77	090
35876		A	Removal of clot in graft	17.82	NA	NA	7.24	6.87	2.94	090
35879		A	Revise graft w/vein	17.41	NA	NA	7.22	6.85	2.89	090
35881		A	Revise graft w/vein	19.35	NA	NA	7.63	7.50	3.24	090
35883		A	Revise graft w/nonauto graft	23.15	NA	NA	8.76	8.09	3.85	090
35884		A	Revise graft w/vein	24.65	NA	NA	8.05	8.03	4.23	090
35901		A	Excision, graft, neck	8.38	NA	NA	4.90	4.74	1.36	090
35903		A	Excision, graft, extremity	9.53	NA	NA	5.39	5.24	1.55	090
35905		A	Excision, graft, thorax	33.52	NA	NA	10.73	11.44	5.75	090
35907		A	Excision, graft, abdomen	37.27	NA	NA	13.12	12.65	6.20	090
36000		A	Place needle in vein	0.18	0.41	0.47	0.07	0.07	0.02	XXX
36002		A	Pseudoaneurysm injection trt	1.96	2.08	2.38	0.80	0.91	0.21	000

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36005		A	Injection ext venography	0.95	7.26	7.99	0.30	0.36	0.11	000
36010		A	Place catheter in vein	2.43	10.29	12.57	0.74	0.83	0.26	XXX
36011		A	Place catheter in vein	3.14	18.58	21.04	1.00	1.08	0.32	XXX
36012		A	Place catheter in vein	3.51	18.24	19.57	1.09	1.27	0.37	XXX
36013		A	Place catheter in artery	2.52	16.41	18.50	0.79	0.87	0.34	XXX
36014		A	Place catheter in artery	3.02	17.33	19.09	0.94	1.13	0.24	XXX
36015		A	Place catheter in artery	3.51	18.38	20.63	1.08	1.30	0.26	XXX
36100		A	Establish access to artery	3.02	9.11	10.74	0.97	1.15	0.48	XXX
36120		A	Establish access to artery	2.01	8.95	9.66	0.57	0.64	0.24	XXX
36140		A	Establish access to artery	2.01	9.18	10.64	0.63	0.71	0.29	XXX
36147		A	Access av dial grft for eval	3.72	17.20	17.20	1.20	1.20	0.36	XXX
36148		A	Access av dial grft for proc	1.00	5.60	5.60	0.31	0.31	0.10	ZZZ
36160		A	Establish access to aorta	2.52	9.54	11.29	0.75	0.95	0.27	XXX
36200		A	Place catheter in aorta	3.02	12.39	13.99	0.92	1.04	0.43	XXX
36215		A	Place catheter in artery	4.67	22.64	25.43	1.53	1.82	0.60	XXX
36216		A	Place catheter in artery	5.27	24.71	27.65	1.73	2.05	0.67	XXX
36217		A	Place catheter in artery	6.29	42.29	47.35	2.08	2.43	0.76	XXX
36218		A	Place catheter in artery	1.01	3.47	3.99	0.33	0.38	0.12	ZZZ
36245		A	Place catheter in artery	4.67	22.75	27.84	1.52	1.96	0.64	XXX
36246		A	Place catheter in artery	5.27	23.62	27.12	1.65	1.97	0.70	XXX
36247		A	Place catheter in artery	6.29	39.15	44.68	1.96	2.33	0.85	XXX
36248		A	Place catheter in artery	1.01	2.75	3.26	0.31	0.38	0.12	ZZZ
36260		A	Insertion of infusion pump	9.91	NA	NA	6.13	5.20	1.52	090
36261		A	Revision of infusion pump	5.63	NA	NA	3.51	3.49	0.95	090
36262		A	Removal of infusion pump	4.11	NA	NA	3.33	2.96	0.62	090
36299		C	Vessel injection procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
36400		A	Bl draw < 3 yrs fem/jugular	0.38	0.37	0.31	0.14	0.10	0.05	XXX
36405		A	Bl draw < 3 yrs scalp vein	0.31	0.37	0.32	0.11	0.10	0.05	XXX
36406		A	Bl draw < 3 yrs other vein	0.18	0.30	0.28	0.07	0.06	0.02	XXX
36410		A	Non-routine bl draw > 3 yrs	0.18	0.35	0.32	0.07	0.05	0.02	XXX
36415		X	Routine venipuncture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36416		B	Capillary blood draw	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36420		A	Vein access cutdown < 1 yr	1.01	NA	NA	0.38	0.29	0.10	XXX
36425		A	Vein access cutdown > 1 yr	0.76	NA	NA	0.28	0.25	0.08	XXX
36430		A	Blood transfusion service	0.00	0.75	0.91	NA	NA	0.01	XXX
36440		A	Bl push transfuse, 2 yr or <	1.03	NA	NA	0.39	0.31	0.18	XXX
36450		A	Bl exchange/transfuse, nb	2.23	NA	NA	0.86	0.83	0.09	XXX
36455		A	Bl exchange/transfuse non-nb	2.43	NA	NA	0.96	0.95	0.11	XXX
36460		A	Transfusion service, fetal	6.58	NA	NA	2.43	2.08	1.01	XXX

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36468		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36469		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36470		A	Injection therapy of vein	1.10	2.63	2.52	0.77	0.71	0.15	010
36471		A	Injection therapy of veins	1.65	2.79	2.77	0.95	0.90	0.23	010
36475		A	Endovenous rf, 1st vein	6.72	38.31	40.25	2.37	2.28	1.02	000
36476		A	Endovenous rf, vein add-on	3.38	6.57	6.68	1.07	1.02	0.53	ZZZ
36478		A	Endovenous laser, 1st vein	6.72	28.94	31.56	2.35	2.34	0.96	000
36479		A	Endovenous laser vein addon	3.38	6.62	7.09	1.10	1.05	0.48	ZZZ
36481		A	Insertion of catheter, vein	6.98	45.38	14.46	2.41	3.53	0.65	000
36500		A	Insertion of catheter, vein	3.51	NA	NA	1.13	1.29	0.39	000
3650F		I	Eeg ordered rvwd reqstd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36510		A	Insertion of catheter, vein	1.09	1.26	1.64	0.43	0.40	0.17	000
36511		A	Apheresis wbc	1.74	NA	NA	0.73	0.66	0.19	000
36512		A	Apheresis rbc	1.74	NA	NA	0.71	0.68	0.12	000
36513		A	Apheresis platelets	1.74	NA	NA	0.74	0.71	0.24	000
36514		A	Apheresis plasma	1.74	10.32	11.71	0.65	0.62	0.19	000
36515		A	Apheresis, adsorp/reinfuse	1.74	44.55	48.95	0.66	0.59	0.17	000
36516		A	Apheresis, selective	1.22	46.41	54.98	0.46	0.43	0.25	000
36522		A	Photopheresis	1.67	29.97	33.81	1.00	0.99	0.12	000
36555		A	Insert non-tunnel cv cath	2.68	3.57	4.33	0.45	0.63	0.15	000
36556		A	Insert non-tunnel cv cath	2.50	3.26	3.54	0.68	0.65	0.23	000
36557		A	Insert tunneled cv cath	5.14	19.61	17.77	3.07	2.73	0.79	010
36558		A	Insert tunneled cv cath	4.84	14.54	16.16	2.39	2.52	0.53	010
36560		A	Insert tunneled cv cath	6.29	17.83	22.78	2.64	2.87	0.42	010
36561		A	Insert tunneled cv cath	6.04	23.28	24.11	3.08	2.93	0.79	010
36563		A	Insert tunneled cv cath	6.24	25.61	24.67	3.29	2.96	0.94	010
36565		A	Insert tunneled cv cath	6.04	18.85	19.42	2.90	2.78	0.93	010
36566		A	Insert tunneled cv cath	6.54	122.41	98.72	3.20	2.96	0.91	010
36568		A	Insert picc cath	1.92	4.90	6.00	0.60	0.64	0.13	000
36569		A	Insert picc cath	1.82	4.21	5.04	0.61	0.68	0.13	000
36570		A	Insert picvad cath	5.36	20.74	24.63	2.50	2.77	0.36	010
36571		A	Insert picvad cath	5.34	26.26	26.93	2.86	2.69	0.72	010
36575		A	Repair tunneled cv cath	0.67	3.29	3.48	0.25	0.25	0.07	000
36576		A	Repair tunneled cv cath	3.24	6.24	6.28	1.78	1.73	0.41	010
36578		A	Replace tunneled cv cath	3.54	9.10	9.67	2.02	2.12	0.38	010
36580		A	Replace cvad cath	1.31	3.93	4.59	0.46	0.47	0.11	000
36581		A	Replace tunneled cv cath	3.48	15.01	16.38	1.66	1.84	0.32	010
36582		A	Replace tunneled cv cath	5.24	21.99	22.85	2.65	2.69	0.64	010
36583		A	Replace tunneled cv cath	5.29	27.77	24.29	3.12	2.78	0.81	010

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36584		A	Replace picc cath	1.20	3.72	4.55	0.55	0.62	0.08	000
36585		A	Replace picvad cath	4.84	21.68	23.66	2.40	2.56	0.48	010
36589		A	Removal tunneled cv cath	2.28	1.97	2.02	1.33	1.34	0.27	010
36590		A	Removal tunneled cv cath	3.35	4.02	3.75	1.90	1.76	0.45	010
36591		T	Draw blood off venous device	0.00	0.51	0.59	NA	NA	0.01	XXX
36592		T	Collect blood from picc	0.00	0.58	0.65	NA	NA	0.01	XXX
36593		A	Declot vascular device	0.00	0.69	0.72	NA	NA	0.01	XXX
36595		A	Mech remov tunneled cv cath	3.59	10.00	12.03	1.27	1.47	0.30	000
36596		A	Mech remov tunneled cv cath	0.75	2.43	2.79	0.41	0.45	0.07	000
36597		A	Reposition venous catheter	1.21	1.86	2.11	0.40	0.47	0.09	000
36598		T	Inj w/fluor, eval cv device	0.74	1.96	2.24	0.22	0.73	0.05	000
36600		A	Withdrawal of arterial blood	0.32	0.45	0.48	0.09	0.08	0.02	XXX
36620		A	Insertion catheter, artery	1.15	NA	NA	0.21	0.18	0.07	000
36625		A	Insertion catheter, artery	2.11	NA	NA	0.61	0.58	0.31	000
36640		A	Insertion catheter, artery	2.10	NA	NA	1.03	0.99	0.31	000
36660		A	Insertion catheter, artery	1.40	NA	NA	0.22	0.29	0.25	000
36680		A	Insert needle, bone cavity	1.20	NA	NA	0.28	0.32	0.15	000
36800		A	Insertion of cannula	2.43	NA	NA	1.74	1.68	0.31	000
36810		A	Insertion of cannula	3.96	NA	NA	1.59	1.45	0.54	000
36815		A	Insertion of cannula	2.62	NA	NA	1.28	1.19	0.41	000
36818		A	Av fuse, uppr arm, cephalic	11.89	NA	NA	5.54	5.25	1.93	090
36819		A	Av fuse, uppr arm, basilic	14.47	NA	NA	6.28	5.89	2.35	090
36820		A	Av fusion/forearm vein	14.47	NA	NA	6.51	6.01	2.34	090
36821		A	Av fusion direct any site	12.11	NA	NA	5.94	5.29	1.95	090
36822		A	Insertion of cannula(s)	5.57	NA	NA	4.14	4.09	0.92	090
36823		A	Insertion of cannula(s)	22.98	NA	NA	10.96	9.88	3.60	090
36825		A	Artery-vein autograft	15.13	NA	NA	6.80	5.20	1.61	090
36830		A	Artery-vein nonautograft	12.03	NA	NA	5.09	4.77	1.96	090
36831		A	Open thrombect av fistula	8.04	NA	NA	3.89	3.64	1.29	090
36832		A	Av fistula revision, open	10.53	NA	NA	4.61	4.31	1.72	090
36833		A	Av fistula revision	11.98	NA	NA	5.11	4.77	1.95	090
36835		A	Artery to vein shunt	7.51	NA	NA	5.06	4.45	1.27	090
36838		A	Dist revas ligation, hemo	21.69	NA	NA	8.61	8.17	3.56	090
36860		A	External cannula declotting	2.01	3.26	3.09	0.81	0.72	0.19	000
36861		A	Cannula declotting	2.52	NA	NA	1.46	1.38	0.35	000
36870		A	Percut thrombect av fistula	5.20	39.49	43.30	2.63	2.91	0.49	090
37140		A	Revision of circulation	25.23	NA	NA	12.02	10.28	3.88	090
37145		A	Revision of circulation	26.24	NA	NA	12.30	11.14	4.13	090
37160		A	Revision of circulation	23.24	NA	NA	11.28	9.52	3.57	090

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37180		A	Revision of circulation	26.24	NA	NA	12.39	10.34	4.03	090
37181		A	Splice spleen/kidney veins	28.37	NA	NA	13.17	11.22	4.37	090
37182		A	Insert hepatic shunt (tips)	16.97	NA	NA	5.15	6.50	1.17	000
37183		A	Remove hepatic shunt (tips)	7.99	127.96	35.06	2.45	3.16	0.54	000
37184		A	Prim art mech thrombectomy	8.66	46.28	54.00	2.98	3.41	1.08	000
37185		A	Prim art m-thrombect add-on	3.28	14.88	17.41	1.02	1.16	0.44	ZZZ
37186		A	Sec art m-thrombect add-on	4.92	29.77	36.77	1.53	1.87	0.69	ZZZ
37187		A	Venous mech thrombectomy	8.03	44.74	52.06	2.68	3.16	0.81	000
37188		A	Venous m-thrombectomy add-on	5.71	37.86	45.10	1.98	2.38	0.51	000
37195		C	Thrombolytic therapy, stroke	0.00	0.00	0.00	0.00	0.00	0.00	XXX
37200		A	Transcatheter biopsy	4.55	NA	NA	1.33	1.68	0.31	000
37201		A	Transcatheter therapy infuse	4.99	NA	NA	2.09	2.42	0.56	000
37202		A	Transcatheter therapy infuse	5.67	NA	NA	2.73	3.21	0.85	000
37203		A	Transcatheter retrieval	5.02	27.14	30.16	1.75	2.10	0.50	000
37204		A	Transcatheter occlusion	18.11	NA	NA	5.39	6.46	1.61	000
37205		A	Transcath iv stent, percut	8.27	92.94	103.81	2.60	3.30	1.13	000
37206		A	Transcath iv stent/perc addl	4.12	56.82	63.44	1.28	1.53	0.59	ZZZ
37207		A	Transcath iv stent, open	8.27	NA	NA	2.87	2.79	1.34	000
37208		A	Transcath iv stent/open addl	4.12	NA	NA	1.23	1.21	0.68	ZZZ
37209		A	Change iv cath at thromb tx	2.27	NA	NA	0.67	0.79	0.24	000
37210		A	Embolization uterine fibroid	10.60	75.61	82.53	3.16	4.14	0.73	000
37215		R	Transcath stent, cca w/eps	19.68	NA	NA	7.63	9.47	3.02	090
37216		N	Transcath stent, cca w/o eps	18.95	NA	NA	8.42	8.33	0.94	090
37250		A	Iv us first vessel add-on	2.10	NA	NA	0.65	0.76	0.33	ZZZ
37251		A	Iv us each add vessel add-on	1.60	NA	NA	0.47	0.52	0.26	ZZZ
37500		A	Endoscopy ligate perf veins	11.67	NA	NA	6.46	6.11	1.89	090
37501		C	Vascular endoscopy procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
37565		A	Ligation of neck vein	12.05	NA	NA	6.61	5.83	1.86	090
37600		A	Ligation of neck artery	12.42	NA	NA	6.26	5.73	1.84	090
37605		A	Ligation of neck artery	14.28	NA	NA	6.61	6.16	2.44	090
37606		A	Ligation of neck artery	8.81	NA	NA	5.63	4.81	1.34	090
37607		A	Ligation of a-v fistula	6.25	NA	NA	3.59	3.37	0.98	090
37609		A	Temporal artery procedure	3.05	4.82	4.48	2.28	2.02	0.46	010
37615		A	Ligation of neck artery	7.80	NA	NA	5.16	4.51	1.19	090
37616		A	Ligation of chest artery	18.97	NA	NA	9.15	8.65	2.92	090
37617		A	Ligation of abdomen artery	23.79	NA	NA	10.15	9.05	3.62	090
37618		A	Ligation of extremity artery	6.03	NA	NA	3.89	3.65	0.95	090
37620		A	Revision of major vein	11.57	NA	NA	5.06	5.69	1.23	090

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37650		A	Revision of major vein	8.49	NA	NA	4.36	4.47	1.34	090
37660		A	Revision of major vein	22.28	NA	NA	10.39	8.85	3.43	090
37700		A	Revise leg vein	3.82	NA	NA	2.74	2.62	0.60	090
37718		A	Ligate/strip short leg vein	7.13	NA	NA	4.22	3.94	1.12	090
37722		A	Ligate/strip long leg vein	8.16	NA	NA	4.46	4.15	1.29	090
37735		A	Removal of leg veins/lesion	10.90	NA	NA	5.29	5.14	1.74	090
37760		A	Ligate leg veins radical	10.78	NA	NA	6.36	5.33	1.65	090
37761		A	Ligate leg veins open	9.13	NA	NA	5.37	5.37	1.41	090
37765		A	Phleb veins - extrem - to 20	7.71	NA	NA	4.10	4.04	1.12	090
37766		A	Phleb veins - extrem 20+	9.66	NA	NA	4.77	4.67	1.46	090
37780		A	Revision of leg vein	3.93	NA	NA	2.84	2.72	0.62	090
37785		A	Ligate/divide/excise vein	3.93	5.29	5.13	2.89	2.74	0.61	090
37788		A	Revascularization, penis	23.33	NA	NA	11.08	11.90	3.59	090
37790		A	Penile venous occlusion	8.43	NA	NA	4.22	4.52	0.59	090
37799		C	Vascular surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38100		A	Removal of spleen, total	19.55	NA	NA	9.18	7.62	2.94	090
38101		A	Removal of spleen, partial	19.55	NA	NA	9.39	7.72	3.01	090
38102		A	Removal of spleen, total	4.79	NA	NA	1.76	1.52	0.71	ZZZ
38115		A	Repair of ruptured spleen	21.88	NA	NA	10.04	8.34	3.09	090
38120		A	Laparoscopy, splenectomy	17.07	NA	NA	9.16	7.83	2.60	090
38129		C	Laparoscope proc, spleen	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38200		A	Injection for spleen x-ray	2.64	NA	NA	1.04	1.01	0.45	000
38204		B	Bl donor search management	2.00	NA	NA	0.73	0.70	0.10	XXX
38205		R	Harvest allogenic stem cells	1.50	NA	NA	0.66	0.63	0.07	000
38206		R	Harvest auto stem cells	1.50	NA	NA	0.65	0.62	0.08	000
38207		I	Cryopreserve stem cells	0.89	NA	NA	0.44	0.45	0.04	XXX
38208		I	Thaw preserved stem cells	0.56	NA	NA	0.28	0.28	0.03	XXX
38209		I	Wash harvest stem cells	0.24	NA	NA	0.12	0.12	0.01	XXX
38210		I	T-cell depletion of harvest	1.57	NA	NA	0.78	0.79	0.08	XXX
38211		I	Tumor cell deplete of harvst	1.42	NA	NA	0.70	0.72	0.07	XXX
38212		I	Rbc depletion of harvest	0.94	NA	NA	0.46	0.48	0.05	XXX
38213		I	Platelet deplete of harvest	0.24	NA	NA	0.12	0.12	0.01	XXX
38214		I	Volume deplete of harvest	0.81	NA	NA	0.40	0.41	0.04	XXX
38215		I	Harvest stem cell concentrte	0.94	NA	NA	0.46	0.48	0.05	XXX
38220		A	Bone marrow aspiration	1.08	2.41	2.86	0.51	0.51	0.09	XXX
38221		A	Bone marrow biopsy	1.37	2.46	2.98	0.64	0.64	0.06	XXX
38230		R	Bone marrow collection	4.85	NA	NA	3.58	3.31	0.79	010
38240		R	Bone marrow/stem transplant	2.24	NA	NA	1.07	1.04	0.12	XXX
38241		R	Bone marrow/stem transplant	2.24	NA	NA	1.08	1.06	0.11	XXX

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38242		A	Lymphocyte infuse transplant	1.71	NA	NA	0.84	0.80	0.08	000
38300		A	Drainage, lymph node lesion	2.36	4.32	4.34	2.22	2.13	0.29	010
38305		A	Drainage, lymph node lesion	6.68	NA	NA	4.91	4.51	0.94	090
38308		A	Incision of lymph channels	6.81	NA	NA	4.45	3.92	1.03	090
38380		A	Thoracic duct procedure	8.46	NA	NA	6.69	5.73	0.77	090
38381		A	Thoracic duct procedure	13.38	NA	NA	6.68	6.62	2.27	090
38382		A	Thoracic duct procedure	10.65	NA	NA	7.06	6.04	1.62	090
38500		A	Biopsy/removal, lymph nodes	3.79	4.40	3.97	2.54	2.23	0.56	010
38505		A	Needle biopsy, lymph nodes	1.14	1.98	2.10	0.71	0.77	0.09	000
38510		A	Biopsy/removal, lymph nodes	6.74	6.42	5.81	4.01	3.52	0.87	010
38520		A	Biopsy/removal, lymph nodes	7.03	NA	NA	4.65	4.18	1.01	090
38525		A	Biopsy/removal, lymph nodes	6.43	NA	NA	4.38	3.77	0.97	090
38530		A	Biopsy/removal, lymph nodes	8.34	NA	NA	5.29	4.64	1.30	090
38542		A	Explore deep node(s), neck	7.95	NA	NA	5.45	4.81	0.95	090
38550		A	Removal, neck/armpit lesion	7.11	NA	NA	5.45	4.61	1.07	090
38555		A	Removal, neck/armpit lesion	15.59	NA	NA	9.06	8.36	2.39	090
38562		A	Removal, pelvic lymph nodes	11.06	NA	NA	6.50	6.17	1.42	090
38564		A	Removal, abdomen lymph nodes	11.38	NA	NA	6.31	5.66	1.63	090
38570		A	Laparoscopy, lymph node biop	9.34	NA	NA	4.42	4.35	0.99	010
38571		A	Laparoscopy, lymphadenectomy	14.76	NA	NA	5.93	6.82	1.06	010
38572		A	Laparoscopy, lymphadenectomy	16.94	NA	NA	7.43	6.84	1.75	010
38589		C	Laparoscope proc, lymphatic	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38700		A	Removal of lymph nodes, neck	12.81	NA	NA	8.54	7.23	1.26	090
38720		A	Removal of lymph nodes, neck	21.95	NA	NA	13.26	11.25	2.43	090
38724		A	Removal of lymph nodes, neck	23.95	NA	NA	14.59	12.13	2.40	090
38740		A	Remove armpit lymph nodes	10.70	NA	NA	6.46	5.55	1.62	090
38745		A	Remove armpit lymph nodes	13.87	NA	NA	7.90	6.74	2.11	090
38746		A	Remove thoracic lymph nodes	4.88	NA	NA	1.56	1.59	0.82	ZZZ
38747		A	Remove abdominal lymph nodes	4.88	NA	NA	1.79	1.55	0.74	ZZZ
38760		A	Remove groin lymph nodes	13.62	NA	NA	7.39	6.58	2.01	090
38765		A	Remove groin lymph nodes	21.91	NA	NA	10.52	9.44	3.05	090
38770		A	Remove pelvis lymph nodes	14.06	NA	NA	6.63	6.86	1.27	090
38780		A	Remove abdomen lymph nodes	17.70	NA	NA	8.67	8.69	1.84	090
38790		A	Inject for lymphatic x-ray	1.29	NA	NA	0.81	0.79	0.17	000
38792		A	Identify sentinel node	0.52	NA	NA	0.50	0.49	0.07	000
38794		A	Access thoracic lymph duct	4.62	NA	NA	2.81	3.31	0.30	090

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38999		C	Blood/lymph system procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39000		A	Exploration of chest	7.57	NA	NA	4.92	4.72	1.20	090
39010		A	Exploration of chest	13.19	NA	NA	6.69	6.76	2.26	090
39200		A	Removal chest lesion	15.09	NA	NA	6.99	6.95	2.56	090
39220		A	Removal chest lesion	19.55	NA	NA	9.19	8.99	3.20	090
39400		A	Visualization of chest	8.05	NA	NA	4.61	4.57	1.35	010
39499		C	Chest procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39501		A	Repair diaphragm laceration	13.98	NA	NA	7.28	6.55	2.12	090
39502		A	Repair paraesophageal hernia	17.18	NA	NA	8.66	7.49	2.64	090
39503		A	Repair of diaphragm hernia	108.91	NA	NA	44.14	35.79	16.81	090
39520		A	Repair of diaphragm hernia	16.74	NA	NA	8.28	7.69	2.66	090
39530		A	Repair of diaphragm hernia	16.30	NA	NA	7.87	7.13	2.61	090
39531		A	Repair of diaphragm hernia	17.31	NA	NA	8.71	7.35	2.67	090
39540		A	Repair of diaphragm hernia	14.57	NA	NA	7.20	6.39	2.25	090
39541		A	Repair of diaphragm hernia	15.75	NA	NA	7.89	6.92	2.45	090
39545		A	Revision of diaphragm	14.67	NA	NA	7.71	7.50	2.46	090
39560		A	Resect diaphragm, simple	13.06	NA	NA	6.75	6.21	2.02	090
39561		A	Resect diaphragm, complex	19.99	NA	NA	11.47	10.24	3.15	090
39599		C	Diaphragm surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4004F		I	Pt tobacco use done rcvd tlk	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40490		A	Biopsy of lip	1.22	1.99	2.01	0.72	0.66	0.12	000
40500		A	Partial excision of lip	4.47	8.35	7.90	4.96	4.58	0.47	090
40510		A	Partial excision of lip	4.82	7.50	7.04	4.45	4.03	0.51	090
40520		A	Partial excision of lip	4.79	7.66	7.34	4.53	4.13	0.54	090
40525		A	Reconstruct lip with flap	7.72	NA	NA	6.63	6.07	0.90	090
40527		A	Reconstruct lip with flap	9.32	NA	NA	7.16	6.85	0.85	090
40530		A	Partial removal of lip	5.54	8.30	7.88	5.04	4.60	0.61	090
4063F		I	Antidepres rxthxpy not rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40650		A	Repair lip	3.78	6.71	6.38	3.65	3.37	0.46	090
40652		A	Repair lip	4.43	7.86	7.48	4.60	4.26	0.55	090
40654		A	Repair lip	5.48	8.83	8.51	5.42	5.04	0.67	090
40700		A	Repair cleft lip/nasal	14.17	NA	NA	9.98	9.16	1.29	090
40701		A	Repair cleft lip/nasal	17.23	NA	NA	11.46	11.14	1.59	090
40702		A	Repair cleft lip/nasal	14.27	NA	NA	7.65	7.67	0.71	090
40720		A	Repair cleft lip/nasal	14.72	NA	NA	11.84	9.88	2.08	090
40761		A	Repair cleft lip/nasal	15.84	NA	NA	12.22	10.59	2.25	090
40799		C	Lip surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
40800		A	Drainage of mouth lesion	1.23	4.05	3.78	2.13	1.96	0.12	010
40801		A	Drainage of mouth lesion	2.63	5.40	4.96	3.13	2.83	0.27	010

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40804		A	Removal, foreign body, mouth	1.30	4.22	3.85	2.17	1.95	0.12	010
40805		A	Removal, foreign body, mouth	2.79	5.36	5.09	3.25	2.89	0.25	010
40806		A	Incision of lip fold	0.31	2.20	2.27	0.55	0.53	0.03	000
40808		A	Biopsy of mouth lesion	1.01	3.70	3.49	1.79	1.67	0.09	010
40810		A	Excision of mouth lesion	1.36	3.87	3.62	1.96	1.80	0.13	010
40812		A	Excise/repair mouth lesion	2.37	4.95	4.57	2.78	2.49	0.23	010
40814		A	Excise/repair mouth lesion	3.52	6.33	5.80	4.42	4.00	0.34	090
40816		A	Excision of mouth lesion	3.77	6.60	6.06	4.53	4.11	0.37	090
40818		A	Excise oral mucosa for graft	2.83	6.21	5.92	4.17	4.00	0.26	090
40819		A	Excise lip or cheek fold	2.51	5.36	4.95	3.61	3.30	0.23	090
40820		A	Treatment of mouth lesion	1.34	5.30	5.15	3.06	2.95	0.13	010
40830		A	Repair mouth laceration	1.82	4.64	4.19	2.36	2.14	0.22	010
40831		A	Repair mouth laceration	2.57	5.85	5.35	3.15	2.95	0.30	010
40840		R	Reconstruction of mouth	9.15	11.37	10.62	6.92	6.43	0.84	090
40842		R	Reconstruction of mouth	9.15	13.05	10.80	8.14	6.48	0.84	090
40843		R	Reconstruction of mouth	12.79	13.41	12.54	7.67	7.01	1.81	090
40844		R	Reconstruction of mouth	16.80	17.51	16.62	11.47	10.79	2.37	090
40845		R	Reconstruction of mouth	19.36	18.90	17.28	13.23	11.87	1.79	090
40899		C	Mouth surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41000		A	Drainage of mouth lesion	1.35	2.79	2.60	1.57	1.44	0.13	010
41005		A	Drainage of mouth lesion	1.31	4.57	4.28	2.00	1.87	0.12	010
41006		A	Drainage of mouth lesion	3.34	6.00	5.51	3.37	3.09	0.30	090
41007		A	Drainage of mouth lesion	3.20	5.97	5.65	3.30	3.06	0.29	090
41008		A	Drainage of mouth lesion	3.46	6.19	5.64	3.55	3.19	0.31	090
41009		A	Drainage of mouth lesion	3.71	6.52	5.96	3.94	3.52	0.34	090
41010		A	Incision of tongue fold	1.11	4.12	3.92	1.75	1.65	0.10	010
41015		A	Drainage of mouth lesion	4.08	6.90	6.33	4.85	4.30	0.37	090
41016		A	Drainage of mouth lesion	4.19	6.91	6.42	4.99	4.46	0.38	090
41017		A	Drainage of mouth lesion	4.19	7.16	6.55	4.99	4.49	0.38	090
41018		A	Drainage of mouth lesion	5.22	7.62	6.98	5.61	4.90	0.48	090
41019		A	Place needles h&n for rt	8.84	NA	NA	4.09	3.73	0.52	000
41100		A	Biopsy of tongue	1.42	2.90	2.73	1.42	1.32	0.13	010
41105		A	Biopsy of tongue	1.47	2.92	2.71	1.47	1.33	0.14	010
41108		A	Biopsy of floor of mouth	1.10	2.69	2.51	1.28	1.16	0.10	010
41110		A	Excision of tongue lesion	1.56	3.90	3.63	1.91	1.74	0.14	010
41112		A	Excision of tongue lesion	2.83	5.74	5.31	3.77	3.44	0.26	090
41113		A	Excision of tongue lesion	3.29	6.07	5.60	4.02	3.64	0.31	090
41114		A	Excision of tongue lesion	8.82	NA	NA	8.00	7.13	0.83	090
41115		A	Excision of tongue fold	1.79	4.42	4.20	2.16	1.93	0.16	010

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41116		A	Excision of mouth lesion	2.52	5.96	5.50	3.25	2.97	0.24	090
41120		A	Partial removal of tongue	11.14	NA	NA	16.14	15.28	1.04	090
41130		A	Partial removal of tongue	15.74	NA	NA	18.40	16.92	1.49	090
41135		A	Tongue and neck surgery	30.14	NA	NA	26.66	23.97	2.90	090
41140		A	Removal of tongue	29.15	NA	NA	28.37	26.17	2.69	090
41145		A	Tongue removal, neck surgery	37.93	NA	NA	34.94	31.61	3.50	090
41150		A	Tongue, mouth, jaw surgery	29.86	NA	NA	27.86	25.25	2.84	090
41153		A	Tongue, mouth, neck surgery	33.59	NA	NA	29.30	26.22	3.16	090
41155		A	Tongue, jaw, & neck surgery	44.30	NA	NA	34.85	30.29	4.27	090
41250		A	Repair tongue laceration	1.96	4.44	3.77	1.92	1.61	0.23	010
41251		A	Repair tongue laceration	2.32	4.55	3.65	2.11	1.80	0.21	010
41252		A	Repair tongue laceration	3.02	5.09	4.57	2.55	2.26	0.34	010
41500		A	Fixation of tongue	3.80	NA	NA	8.09	7.49	0.35	090
41510		A	Tongue to lip surgery	3.51	NA	NA	7.95	7.03	0.32	090
41512		A	Tongue suspension	6.86	NA	NA	9.81	8.95	0.34	090
41520		A	Reconstruction, tongue fold	2.83	6.08	5.69	3.81	3.52	0.26	090
41530		A	Tongue base vol reduction	4.51	74.84	74.78	6.19	5.82	0.22	010
41599		C	Tongue and mouth surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41800		A	Drainage of gum lesion	1.27	5.26	4.54	2.40	2.05	0.14	010
41805		A	Removal foreign body, gum	1.34	5.45	4.66	3.29	2.88	0.12	010
41806		A	Removal foreign body,jawbone	2.79	6.15	5.60	3.91	3.53	0.39	010
41820		R	Excision, gum, each quadrant	0.00	0.00	0.00	0.00	0.00	0.00	000
41821		R	Excision of gum flap	0.00	0.00	0.00	0.00	0.00	0.00	000
41822		R	Excision of gum lesion	2.41	4.95	4.61	2.38	1.99	0.22	010
41823		R	Excision of gum lesion	3.77	7.10	6.69	4.64	4.19	0.34	090
41825		A	Excision of gum lesion	1.41	3.90	3.68	1.76	1.73	0.13	010
41826		A	Excision of gum lesion	2.41	5.52	4.78	3.10	2.69	0.22	010
41827		A	Excision of gum lesion	3.83	7.43	6.77	4.25	3.77	0.34	090
41828		R	Excision of gum lesion	3.14	4.71	4.25	2.50	2.17	0.29	010
41830		R	Removal of gum tissue	3.45	6.52	5.99	3.94	3.48	0.31	010
41850		R	Treatment of gum lesion	0.00	0.00	0.00	0.00	0.00	0.00	000
41870		R	Gum graft	0.00	0.00	0.00	0.00	0.00	0.00	000
41872		R	Repair gum	3.01	6.24	5.92	3.81	3.52	0.41	090
41874		R	Repair tooth socket	3.19	6.26	5.77	3.47	3.09	0.29	090
41899		C	Dental surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42000		A	Drainage mouth roof lesion	1.28	2.73	2.60	1.46	1.31	0.12	010
42100		A	Biopsy roof of mouth	1.36	2.50	2.33	1.52	1.38	0.13	010
42104		A	Excision lesion, mouth roof	1.69	3.84	3.49	1.97	1.76	0.16	010
42106		A	Excision lesion, mouth roof	2.15	4.79	4.37	2.51	2.31	0.20	010

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42107		A	Excision lesion, mouth roof	4.56	7.34	6.73	4.58	4.09	0.41	090
42120		A	Remove palate/lesion	11.86	NA	NA	14.20	12.91	1.12	090
42140		A	Excision of uvula	1.70	4.84	4.52	2.38	2.21	0.15	090
42145		A	Repair palate, pharynx/uvula	17.46	NA	NA	12.63	8.97	0.89	090
42160		A	Treatment mouth roof lesion	1.85	4.12	4.04	2.02	1.95	0.17	010
42180		A	Repair palate	2.55	3.86	3.48	2.35	2.09	0.23	010
42182		A	Repair palate	3.87	4.59	4.23	2.99	2.76	0.36	010
42200		A	Reconstruct cleft palate	12.53	NA	NA	10.16	9.50	1.15	090
42205		A	Reconstruct cleft palate	13.66	NA	NA	10.08	9.55	1.26	090
42210		A	Reconstruct cleft palate	15.03	NA	NA	12.79	11.26	2.14	090
42215		A	Reconstruct cleft palate	8.99	NA	NA	8.16	8.08	1.26	090
42220		A	Reconstruct cleft palate	7.16	NA	NA	7.42	6.57	0.35	090
42225		A	Reconstruct cleft palate	9.77	NA	NA	13.31	13.56	0.89	090
42226		A	Lengthening of palate	10.35	NA	NA	13.17	12.88	0.95	090
42227		A	Lengthening of palate	9.90	NA	NA	12.18	12.48	0.91	090
42235		A	Repair palate	8.01	NA	NA	11.27	10.64	0.73	090
42260		A	Repair nose to lip fistula	10.22	11.23	10.30	7.44	6.69	0.93	090
42280		A	Preparation, palate mold	1.59	2.58	2.30	1.30	1.04	0.24	010
42281		A	Insertion, palate prosthesis	1.98	3.39	3.08	2.04	1.85	0.18	010
42299		C	Palate/uvula surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42300		A	Drainage of salivary gland	1.98	3.43	3.18	2.03	1.86	0.19	010
42305		A	Drainage of salivary gland	6.31	NA	NA	5.09	4.58	0.62	090
42310		A	Drainage of salivary gland	1.61	2.58	2.40	1.69	1.53	0.15	010
42320		A	Drainage of salivary gland	2.40	4.14	3.80	2.28	2.07	0.22	010
42330		A	Removal of salivary stone	2.26	3.78	3.51	2.12	1.90	0.21	010
42335		A	Removal of salivary stone	3.41	6.31	5.83	3.43	3.13	0.31	090
42340		A	Removal of salivary stone	4.72	7.45	6.84	4.23	3.84	0.43	090
42400		A	Biopsy of salivary gland	0.78	2.00	1.94	0.70	0.69	0.07	000
42405		A	Biopsy of salivary gland	3.34	4.37	4.16	2.62	2.40	0.31	010
42408		A	Excision of salivary cyst	4.66	7.20	6.63	4.04	3.63	0.42	090
42409		A	Drainage of salivary cyst	2.91	5.78	5.33	3.00	2.74	0.26	090
42410		A	Excise parotid gland/lesion	9.57	NA	NA	6.79	6.07	1.02	090
42415		A	Excise parotid gland/lesion	18.12	NA	NA	11.42	10.15	1.76	090
42420		A	Excise parotid gland/lesion	21.00	NA	NA	12.80	11.36	2.04	090
42425		A	Excise parotid gland/lesion	13.42	NA	NA	8.81	7.93	1.31	090
42426		A	Excise parotid gland/lesion	22.66	NA	NA	13.32	11.87	2.24	090
42440		A	Excise submaxillary gland	7.13	NA	NA	5.26	4.71	0.69	090
42450		A	Excise sublingual gland	4.74	7.08	6.54	4.76	4.34	0.46	090
42500		A	Repair salivary duct	4.42	6.89	6.35	4.62	4.22	0.42	090

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42505		A	Repair salivary duct	6.32	8.27	7.60	5.76	5.21	0.58	090
42507		A	Parotid duct diversion	6.25	NA	NA	7.31	6.78	0.57	090
42508		A	Parotid duct diversion	9.33	NA	NA	9.56	8.91	0.85	090
42509		A	Parotid duct diversion	11.76	NA	NA	10.73	9.44	1.66	090
42510		A	Parotid duct diversion	8.35	NA	NA	8.32	7.64	0.76	090
42550		A	Injection for salivary x-ray	1.25	2.00	2.43	0.37	0.45	0.08	000
42600		A	Closure of salivary fistula	4.94	7.62	7.14	4.34	4.01	0.45	090
4260F		I	Wound srfc culturetech used	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4261F		I	Tech other than surfc cultr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42650		A	Dilation of salivary duct	0.77	1.40	1.29	0.78	0.72	0.07	000
4265F		I	Wet-dry dressings Rx-recmd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42660		A	Dilation of salivary duct	1.13	1.67	1.52	0.96	0.85	0.10	000
42665		A	Ligation of salivary duct	2.63	5.54	5.11	2.86	2.63	0.24	090
4266F		I	No wet-dry drssings Rx-recmd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4268F		I	Pt ed re comp thxpy rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42699		C	Salivary surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4269F		I	Appropos mthd offloading Rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42700		A	Drainage of tonsil abscess	1.67	3.24	3.02	1.90	1.77	0.16	010
4270F		I	Pt rcvng anti r-viral thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42720		A	Drainage of throat abscess	6.31	5.69	5.14	4.16	3.70	0.60	010
42725		A	Drainage of throat abscess	12.41	NA	NA	9.08	8.16	1.14	090
4275F		I	Hep b vac inj admin/ rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4279F		I	PCP prophylaxis Rxd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42800		A	Biopsy of throat	1.44	2.69	2.50	1.53	1.40	0.13	010
42802		A	Biopsy of throat	1.59	4.40	4.37	1.93	1.85	0.15	010
42804		A	Biopsy of upper nose/throat	1.29	3.79	3.71	1.70	1.63	0.12	010
42806		A	Biopsy of upper nose/throat	1.63	4.09	3.99	1.87	1.78	0.15	010
42808		A	Excise pharynx lesion	2.35	3.60	3.35	1.98	1.81	0.22	010
42809		A	Remove pharynx foreign body	1.86	2.56	2.37	1.59	1.42	0.19	010
4280F		I	PCP prophylax Rxd 3mon low %	0.00	0.00	0.00	0.00	0.00	0.00	XXX
42810		A	Excision of neck cyst	3.38	6.75	6.29	4.27	3.88	0.31	090
42815		A	Excision of neck cyst	7.31	NA	NA	7.41	6.73	0.72	090
42820		A	Remove tonsils and adenoids	4.22	NA	NA	3.52	3.19	0.39	090
42821		A	Remove tonsils and adenoids	4.36	NA	NA	3.66	3.35	0.40	090
42825		A	Removal of tonsils	3.51	NA	NA	3.45	3.16	0.32	090
42826		A	Removal of tonsils	3.45	NA	NA	3.22	2.96	0.32	090
42830		A	Removal of adenoids	2.65	NA	NA	2.85	2.61	0.24	090
42831		A	Removal of adenoids	2.81	NA	NA	3.10	2.87	0.26	090

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42835		A	Removal of adenoids	2.38	NA	NA	2.72	2.39	0.22	090
42836		A	Removal of adenoids	3.26	NA	NA	3.14	2.90	0.30	090
42842		A	Extensive surgery of throat	12.23	NA	NA	14.00	12.60	1.13	090
42844		A	Extensive surgery of throat	17.78	NA	NA	18.35	16.77	1.64	090
42845		A	Extensive surgery of throat	32.56	NA	NA	26.42	23.68	3.01	090
42860		A	Excision of tonsil tags	2.30	NA	NA	2.68	2.47	0.21	090
42870		A	Excision of lingual tonsil	5.52	NA	NA	9.56	9.04	0.50	090
42890		A	Partial removal of pharynx	19.13	NA	NA	18.20	16.20	1.82	090
42892		A	Revision of pharyngeal walls	26.03	NA	NA	23.44	20.45	2.45	090
42894		A	Revision of pharyngeal walls	33.92	NA	NA	28.84	25.33	3.18	090
42900		A	Repair throat wound	5.29	NA	NA	3.78	3.40	0.49	010
42950		A	Reconstruction of throat	8.27	NA	NA	12.36	11.74	0.80	090
42953		A	Repair throat, esophagus	9.45	NA	NA	15.36	15.04	0.94	090
42955		A	Surgical opening of throat	8.01	NA	NA	11.71	10.83	0.73	090
42960		A	Control throat bleeding	2.38	NA	NA	2.13	1.92	0.22	010
42961		A	Control throat bleeding	5.77	NA	NA	5.40	4.92	0.53	090
42962		A	Control throat bleeding	7.40	NA	NA	6.39	5.80	0.68	090
42970		A	Control nose/throat bleeding	5.82	NA	NA	4.54	4.07	0.61	090
42971		A	Control nose/throat bleeding	6.60	NA	NA	5.60	5.03	0.61	090
42972		A	Control nose/throat bleeding	7.59	NA	NA	6.07	5.43	0.70	090
42999		C	Throat surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
4300F		I	Pt rcvng warf thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4301F		I	Pt not rcvng warf thxpy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43020		A	Incision of esophagus	8.23	NA	NA	6.19	5.14	0.75	090
43030		A	Throat muscle surgery	7.99	NA	NA	5.69	5.18	0.84	090
43045		A	Incision of esophagus	21.88	NA	NA	10.51	10.48	3.68	090
4305F		I	Pt ed re ft care inspct rcvd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4306F		I	Pt tlk psych & Rx opd addic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43100		A	Excision of esophagus lesion	9.66	NA	NA	7.10	6.15	0.88	090
43101		A	Excision of esophagus lesion	17.07	NA	NA	7.98	7.95	2.89	090
43107		A	Removal of esophagus	44.18	NA	NA	19.58	18.35	7.12	090
43108		A	Removal of esophagus	82.87	NA	NA	34.14	26.94	12.79	090
43112		A	Removal of esophagus	47.48	NA	NA	19.89	19.03	7.77	090
43113		A	Removal of esophagus	80.06	NA	NA	34.29	28.92	12.35	090
43116		A	Partial removal of esophagus	92.99	NA	NA	47.97	34.66	8.64	090
43117		A	Partial removal of esophagus	43.65	NA	NA	18.18	17.25	7.14	090
43118		A	Partial removal of esophagus	67.07	NA	NA	28.32	22.77	10.34	090
43121		A	Partial removal of esophagus	51.43	NA	NA	19.87	18.56	8.70	090
43122		A	Partial removal of esophagus	44.18	NA	NA	19.98	17.79	6.96	090

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43123		A	Partial removal of esophagus	83.12	NA	NA	35.42	27.48	12.83	090
43124		A	Removal of esophagus	69.09	NA	NA	25.92	23.87	11.68	090
43130		A	Removal of esophagus pouch	12.53	NA	NA	8.10	7.33	1.43	090
43135		A	Removal of esophagus pouch	26.17	NA	NA	11.26	10.39	4.31	090
43200		A	Esophagus endoscopy	1.59	3.80	3.84	1.14	1.07	0.16	000
43201		A	Esoph scope w/submucous inj	2.09	5.13	5.35	1.20	1.22	0.22	000
43202		A	Esophagus endoscopy, biopsy	1.89	5.06	5.23	1.08	1.04	0.21	000
43204		A	Esoph scope w/sclerosis inj	3.76	NA	NA	1.90	1.96	0.42	000
43205		A	Esophagus endoscopy/ligation	3.78	NA	NA	1.91	1.96	0.40	000
4320F		I	Pt talk psychsoc+rx oh dpnd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43215		A	Esophagus endoscopy	2.60	NA	NA	1.37	1.33	0.30	000
43216		A	Esophagus endoscopy/lesion	2.40	3.01	2.69	1.29	1.27	0.25	000
43217		A	Esophagus endoscopy	2.90	6.31	6.57	1.46	1.41	0.36	000
43219		A	Esophagus endoscopy	2.80	NA	NA	1.53	1.56	0.34	000
43220		A	Esoph endoscopy, dilation	2.10	NA	NA	1.18	1.15	0.23	000
43226		A	Esoph endoscopy, dilation	2.34	NA	NA	1.27	1.27	0.27	000
43227		A	Esoph endoscopy, repair	3.59	NA	NA	1.79	1.78	0.40	000
43228		A	Esoph endoscopy, ablation	3.76	NA	NA	1.89	1.93	0.42	000
43231		A	Esoph endoscopy w/us exam	3.19	NA	NA	1.64	1.69	0.35	000
43232		A	Esoph endoscopy w/us fn bx	4.47	NA	NA	2.16	2.23	0.51	000
43234		A	Upper GI endoscopy, exam	2.01	4.83	5.02	1.08	1.04	0.25	000
43235		A	Uppr gi endoscopy, diagnosis	2.39	4.72	5.14	1.29	1.32	0.27	000
43236		A	Uppr gi scope w/submuc inj	2.92	5.86	6.45	1.54	1.60	0.32	000
43237		A	Endoscopic us exam, esoph	3.98	NA	NA	1.99	2.07	0.44	000
43238		A	Uppr gi endoscopy w/us fn bx	5.02	NA	NA	2.42	2.54	0.55	000
43239		A	Upper GI endoscopy, biopsy	2.87	5.43	5.86	1.50	1.53	0.32	000
43240		A	Esoph endoscope w/drain cyst	6.85	NA	NA	3.24	3.33	0.74	000
43241		A	Upper GI endoscopy with tube	2.59	NA	NA	1.37	1.39	0.29	000
43242		A	Uppr gi endoscopy w/us fn bx	7.30	NA	NA	3.46	3.59	0.78	000
43243		A	Upper gi endoscopy & inject	4.56	NA	NA	2.24	2.31	0.49	000
43244		A	Upper GI endoscopy/ligation	5.04	NA	NA	2.47	2.57	0.53	000
43245		A	Uppr gi scope dilate strictr	3.18	NA	NA	1.61	1.61	0.37	000
43246		A	Place gastrostomy tube	4.32	NA	NA	2.08	2.10	0.51	000
43247		A	Operative upper GI endoscopy	3.38	NA	NA	1.72	1.75	0.38	000
43248		A	Uppr gi endoscopy/guide wire	3.15	NA	NA	1.64	1.71	0.34	000
43249		A	Esoph endoscopy, dilation	2.90	NA	NA	1.52	1.57	0.32	000
43250		A	Upper GI endoscopy/tumor	3.20	NA	NA	1.61	1.60	0.38	000
43251		A	Operative upper GI endoscopy	3.69	NA	NA	1.86	1.89	0.41	000
43255		A	Operative upper GI endoscopy	4.81	NA	NA	2.37	2.45	0.51	000

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43256		A	Uppr gi endoscopy w/stent	4.34	NA	NA	2.11	2.18	0.49	000
43257		A	Uppr gi scope w/thrml txmnt	5.50	NA	NA	2.74	2.60	0.58	000
43258		A	Operative upper GI endoscopy	4.54	NA	NA	2.24	2.31	0.49	000
43259		A	Endoscopic ultrasound exam	5.19	NA	NA	2.53	2.63	0.55	000
43260		A	Endo cholangiopancreatograph	5.95	NA	NA	2.86	2.98	0.63	000
43261		A	Endo cholangiopancreatograph	6.26	NA	NA	3.01	3.12	0.67	000
43262		A	Endo cholangiopancreatograph	7.38	NA	NA	3.50	3.63	0.78	000
43263		A	Endo cholangiopancreatograph	7.28	NA	NA	3.42	3.60	0.77	000
43264		A	Endo cholangiopancreatograph	8.89	NA	NA	4.16	4.33	0.94	000
43265		A	Endo cholangiopancreatograph	10.00	NA	NA	4.65	4.84	1.06	000
43267		A	Endo cholangiopancreatograph	7.38	NA	NA	3.48	3.59	0.78	000
43268		A	Endo cholangiopancreatograph	7.38	NA	NA	3.63	3.77	0.78	000
43269		A	Endo cholangiopancreatograph	8.20	NA	NA	3.86	4.01	0.88	000
43271		A	Endo cholangiopancreatograph	7.38	NA	NA	3.49	3.62	0.79	000
43272		A	Endo cholangiopancreatograph	7.38	NA	NA	3.50	3.61	0.78	000
43273		A	Endoscopic pancreatoscopy	2.24	NA	NA	0.98	1.07	0.11	ZZZ
43279		A	Lap myotomy, heller	22.10	NA	NA	10.39	8.79	1.10	090
43280		A	Laparoscopy, fundoplasty	18.10	NA	NA	8.89	7.63	2.78	090
43281		A	Lap paraesophag hern repair	26.60	NA	NA	12.03	12.03	4.08	090
43282		A	Lap paraesoph her rpr w/mesh	30.10	NA	NA	13.32	13.32	4.62	090
43289		C	Laparoscope proc, esoph	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43300		A	Repair of esophagus	9.33	NA	NA	7.11	6.24	0.85	090
43305		A	Repair esophagus and fistula	18.10	NA	NA	11.20	9.86	1.68	090
4330F		I	Cnslng epi spec sfty issues	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43310		A	Repair of esophagus	26.26	NA	NA	11.59	11.13	4.45	090
43312		A	Repair esophagus and fistula	29.25	NA	NA	10.57	11.46	4.96	090
43313		A	Esophagoplasty congenital	48.45	NA	NA	19.67	18.13	8.18	090
43314		A	Tracheo-esophagoplasty cong	53.43	NA	NA	29.37	23.95	4.95	090
43320		A	Fuse esophagus & stomach	23.31	NA	NA	11.22	10.12	3.58	090
43324		A	Revise esophagus & stomach	22.99	NA	NA	10.89	9.46	3.59	090
43325		A	Revise esophagus & stomach	22.60	NA	NA	11.12	9.50	3.47	090
43326		A	Revise esophagus & stomach	22.28	NA	NA	10.86	10.05	3.64	090
43330		A	Repair of esophagus	22.19	NA	NA	10.62	9.19	3.44	090
43331		A	Repair of esophagus	23.06	NA	NA	10.34	10.39	3.89	090
43340		A	Fuse esophagus & intestine	22.99	NA	NA	11.26	9.77	3.53	090
43341		A	Fuse esophagus & intestine	24.23	NA	NA	12.62	11.55	4.09	090
43350		A	Surgical opening, esophagus	19.49	NA	NA	10.53	9.07	2.99	090
43351		A	Surgical opening, esophagus	22.05	NA	NA	10.72	10.46	3.71	090
43352		A	Surgical opening, esophagus	17.81	NA	NA	8.76	8.69	3.00	090

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43360		A	Gastrointestinal repair	40.11	NA	NA	16.10	16.05	6.77	090
43361		A	Gastrointestinal repair	45.68	NA	NA	21.28	18.57	7.04	090
43400		A	Ligate esophagus veins	25.60	NA	NA	13.76	14.03	2.71	090
43401		A	Esophagus surgery for veins	26.49	NA	NA	12.55	10.75	4.07	090
43405		A	Ligate/staple esophagus	24.73	NA	NA	13.56	11.61	3.79	090
4340F		I	Cnslng chldbrng+ women epi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
43410		A	Repair esophagus wound	16.41	NA	NA	8.34	8.23	2.77	090
43415		A	Repair esophagus wound	28.91	NA	NA	14.12	12.93	4.75	090
43420		A	Repair esophagus opening	16.78	NA	NA	10.54	8.67	1.55	090
43425		A	Repair esophagus opening	25.04	NA	NA	12.92	11.77	3.85	090
43450		A	Dilate esophagus	1.38	2.37	2.60	0.86	0.89	0.15	000
43453		A	Dilate esophagus	1.51	5.43	6.02	0.92	0.96	0.16	000
43456		A	Dilate esophagus	2.57	11.44	12.68	1.38	1.40	0.28	000
43458		A	Dilate esophagus	3.06	6.32	6.74	1.59	1.59	0.34	000
43460		A	Pressure treatment esophagus	3.79	NA	NA	1.93	1.86	0.40	000
43496		C	Free jejunum flap, microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
43499		C	Esophagus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43500		A	Surgical opening of stomach	12.79	NA	NA	6.76	5.78	1.96	090
43501		A	Surgical repair of stomach	22.60	NA	NA	10.89	9.19	3.44	090
43502		A	Surgical repair of stomach	25.69	NA	NA	12.21	10.23	3.95	090
43510		A	Surgical opening of stomach	15.14	NA	NA	9.08	8.04	1.60	090
43520		A	Incision of pyloric muscle	11.29	NA	NA	5.87	5.36	1.81	090
43600		A	Biopsy of stomach	1.91	NA	NA	0.79	0.81	0.21	000
43605		A	Biopsy of stomach	13.72	NA	NA	7.08	5.97	2.08	090
43610		A	Excision of stomach lesion	16.34	NA	NA	8.10	6.83	2.49	090
43611		A	Excision of stomach lesion	20.38	NA	NA	10.10	8.52	3.10	090
43620		A	Removal of stomach	34.04	NA	NA	15.02	12.76	5.25	090
43621		A	Removal of stomach	39.53	NA	NA	17.09	14.13	6.08	090
43622		A	Removal of stomach	40.03	NA	NA	17.31	14.30	6.17	090
43631		A	Removal of stomach, partial	24.51	NA	NA	11.65	9.85	3.74	090
43632		A	Removal of stomach, partial	35.14	NA	NA	15.56	12.49	5.38	090
43633		A	Removal of stomach, partial	33.14	NA	NA	14.75	12.00	5.06	090
43634		A	Removal of stomach, partial	36.64	NA	NA	16.25	13.23	5.65	090
43635		A	Removal of stomach, partial	2.06	NA	NA	0.76	0.64	0.32	ZZZ
43640		A	Vagotomy & pylorus repair	19.56	NA	NA	9.87	8.26	2.97	090
43641		A	Vagotomy & pylorus repair	19.81	NA	NA	10.04	8.30	3.04	090
43644		A	Lap gastric bypass/roux-en-y	29.40	NA	NA	13.87	11.75	4.49	090
43645		A	Lap gastr bypass incl smll i	31.53	NA	NA	14.75	12.41	4.85	090
43647		C	Lap impl electrode, antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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43648		C	Lap revise/remv eltrd antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43651		A	Laparoscopy, vagus nerve	10.13	NA	NA	6.10	5.23	1.57	090
43652		A	Laparoscopy, vagus nerve	12.13	NA	NA	6.84	5.83	1.88	090
43653		A	Laparoscopy, gastrostomy	8.48	NA	NA	5.71	4.86	1.28	090
43659		C	Laparoscope proc, stom	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43752		A	Nasal/orogastric w/stent	0.81	NA	NA	0.26	0.28	0.06	000
43760		A	Change gastrostomy tube	0.90	10.23	8.45	0.34	0.37	0.11	000
43761		A	Reposition gastrostomy tube	2.01	1.00	1.12	0.68	0.74	0.17	000
43770		A	Lap place gastr adj device	18.00	NA	NA	9.86	8.39	2.74	090
43771		A	Lap revise gastr adj device	20.79	NA	NA	10.94	9.25	3.19	090
43772		A	Lap rmvl gastr adj device	15.70	NA	NA	8.05	6.93	2.42	090
43773		A	Lap replace gastr adj device	20.79	NA	NA	10.94	9.26	3.19	090
43774		A	Lap rmvl gastr adj all parts	15.76	NA	NA	8.16	6.98	2.41	090
43775		A	Lap sleeve gastrectomy	21.56	NA	NA	10.99	10.99	3.31	090
43800		A	Reconstruction of pylorus	15.43	NA	NA	7.76	6.58	2.38	090
43810		A	Fusion of stomach and bowel	16.88	NA	NA	8.40	7.02	2.60	090
43820		A	Fusion of stomach and bowel	22.53	NA	NA	10.91	8.83	3.43	090
43825		A	Fusion of stomach and bowel	21.76	NA	NA	10.65	8.95	3.34	090
43830		A	Place gastrostomy tube	10.85	NA	NA	6.56	5.64	1.61	090
43831		A	Place gastrostomy tube	8.49	NA	NA	6.24	5.39	1.29	090
43832		A	Place gastrostomy tube	17.34	NA	NA	8.89	7.79	2.59	090
43840		A	Repair of stomach lesion	22.83	NA	NA	11.01	8.97	3.46	090
43842		N	V-band gastroplasty	21.03	NA	NA	9.74	9.19	1.05	090
43843		A	Gastroplasty w/o v-band	21.21	NA	NA	10.21	8.70	3.26	090
43845		A	Gastroplasty duodenal switch	33.30	NA	NA	15.77	12.95	5.11	090
43846		A	Gastric bypass for obesity	27.41	NA	NA	13.44	11.24	4.19	090
43847		A	Gastric bypass incl small i	30.28	NA	NA	14.52	11.93	4.65	090
43848		A	Revision gastroplasty	32.75	NA	NA	15.37	12.91	5.00	090
43850		A	Revise stomach-bowel fusion	27.58	NA	NA	12.91	10.67	4.25	090
43855		A	Revise stomach-bowel fusion	28.69	NA	NA	12.50	10.98	4.42	090
43860		A	Revise stomach-bowel fusion	27.89	NA	NA	13.02	10.91	4.25	090
43865		A	Revise stomach-bowel fusion	29.05	NA	NA	13.45	11.26	4.47	090
43870		A	Repair stomach opening	11.44	NA	NA	6.31	5.36	1.72	090
43880		A	Repair stomach-bowel fistula	27.18	NA	NA	12.68	10.69	4.11	090
43881		C	Impl/redo electrd, antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43882		C	Revise/remove electrd antrum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43886		A	Revise gastric port, open	4.64	NA	NA	4.32	3.69	0.70	090
43887		A	Remove gastric port, open	4.32	NA	NA	3.77	3.27	0.65	090
43888		A	Change gastric port, open	6.44	NA	NA	4.98	4.26	0.97	090

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43999		C	Stomach surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44005		A	Freeing of bowel adhesion	18.46	NA	NA	8.85	7.47	2.77	090
44010		A	Incision of small bowel	14.26	NA	NA	7.27	6.20	2.16	090
44015		A	Insert needle cath bowel	2.62	NA	NA	0.94	0.83	0.40	ZZZ
44020		A	Explore small intestine	16.22	NA	NA	7.99	6.75	2.44	090
44021		A	Decompress small bowel	16.31	NA	NA	8.05	6.90	2.48	090
44025		A	Incision of large bowel	16.51	NA	NA	8.17	6.88	2.47	090
44050		A	Reduce bowel obstruction	15.52	NA	NA	7.81	6.59	2.35	090
44055		A	Correct malrotation of bowel	25.63	NA	NA	11.61	9.74	3.91	090
44100		A	Biopsy of bowel	2.01	NA	NA	0.87	0.91	0.22	000
44110		A	Excise intestine lesion(s)	14.04	NA	NA	7.21	6.08	2.08	090
44111		A	Excision of bowel lesion(s)	16.52	NA	NA	8.15	6.84	2.48	090
44120		A	Removal of small intestine	20.82	NA	NA	9.73	8.12	3.13	090
44121		A	Removal of small intestine	4.44	NA	NA	1.63	1.39	0.66	ZZZ
44125		A	Removal of small intestine	20.03	NA	NA	9.57	8.03	2.94	090
44126		A	Enterectomy w/o taper, cong	42.23	NA	NA	19.12	15.74	6.50	090
44127		A	Enterectomy w/taper, cong	49.30	NA	NA	21.64	17.88	7.59	090
44128		A	Enterectomy cong, add-on	4.44	NA	NA	1.64	1.40	0.68	ZZZ
44130		A	Bowel to bowel fusion	22.11	NA	NA	10.71	8.67	3.29	090
44132		R	Enterectomy, cadaver donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44133		R	Enterectomy, live donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44135		R	Intestine transplnt, cadaver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44136		R	Intestine transplant, live	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44137		C	Remove intestinal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44139		A	Mobilization of colon	2.23	NA	NA	0.82	0.70	0.33	ZZZ
44140		A	Partial removal of colon	22.59	NA	NA	10.97	9.27	3.35	090
44141		A	Partial removal of colon	29.91	NA	NA	15.71	12.93	4.46	090
44143		A	Partial removal of colon	27.79	NA	NA	13.84	11.69	4.14	090
44144		A	Partial removal of colon	29.91	NA	NA	14.39	11.85	4.46	090
44145		A	Partial removal of colon	28.58	NA	NA	13.18	11.11	4.08	090
44146		A	Partial removal of colon	35.30	NA	NA	18.06	15.00	4.95	090
44147		A	Partial removal of colon	33.69	NA	NA	15.01	11.98	4.89	090
44150		A	Removal of colon	30.18	NA	NA	16.73	14.00	4.42	090
44151		A	Removal of colon/ileostomy	34.92	NA	NA	18.33	15.45	5.38	090
44155		A	Removal of colon/ileostomy	34.42	NA	NA	18.19	15.11	4.67	090
44156		A	Removal of colon/ileostomy	37.42	NA	NA	20.08	16.75	5.76	090
44157		A	Colectomy w/ileoanal anast	35.70	NA	NA	18.83	15.66	5.49	090
44158		A	Colectomy w/neo-rectum pouch	36.70	NA	NA	18.97	15.86	5.65	090
44160		A	Removal of colon	20.89	NA	NA	10.23	8.57	3.08	090

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44180		A	Lap, enterolysis	15.27	NA	NA	7.69	6.60	2.28	090
44186		A	Lap, jejunostomy	10.38	NA	NA	5.84	5.11	1.60	090
44187		A	Lap, ileo/jejuno-stomy	17.40	NA	NA	10.54	8.95	2.38	090
44188		A	Lap, colostomy	19.35	NA	NA	11.44	9.73	2.76	090
44202		A	Lap, enterectomy	23.39	NA	NA	11.34	9.55	3.49	090
44203		A	Lap resect s/intestine, addl	4.44	NA	NA	1.64	1.38	0.68	ZZZ
44204		A	Laparo partial colectomy	26.42	NA	NA	12.39	10.38	3.76	090
44205		A	Lap colectomy part w/ileum	22.95	NA	NA	10.86	9.14	3.26	090
44206		A	Lap part colectomy w/stoma	29.79	NA	NA	14.30	12.04	4.37	090
44207		A	L colectomy/coloproctostomy	31.92	NA	NA	14.33	11.93	4.46	090
44208		A	L colectomy/coloproctostomy	33.99	NA	NA	16.56	13.83	4.62	090
44210		A	Laparo total proctocolectomy	30.09	NA	NA	15.31	12.82	4.19	090
44211		A	Lap colectomy w/proctectomy	37.08	NA	NA	19.07	15.68	5.70	090
44212		A	Laparo total proctocolectomy	34.58	NA	NA	17.82	14.92	4.59	090
44213		A	Lap, mobil splenic fl add-on	3.50	NA	NA	1.29	1.09	0.49	ZZZ
44227		A	Lap, close enterostomy	28.62	NA	NA	13.35	11.20	4.23	090
44238		C	Laparoscope proc, intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44300		A	Open bowel to skin	13.75	NA	NA	7.26	6.19	2.10	090
44310		A	Ileostomy/jejunostomy	17.59	NA	NA	8.68	7.32	2.49	090
44312		A	Revision of ileostomy	9.43	NA	NA	5.48	4.89	1.24	090
44314		A	Revision of ileostomy	16.74	NA	NA	8.69	7.50	2.27	090
44316		A	Devise bowel pouch	23.59	NA	NA	11.55	9.62	3.62	090
44320		A	Colostomy	19.91	NA	NA	10.17	8.57	2.92	090
44322		A	Colostomy with biopsies	13.32	NA	NA	11.47	9.80	2.04	090
44340		A	Revision of colostomy	9.28	NA	NA	6.31	5.30	1.33	090
44345		A	Revision of colostomy	17.22	NA	NA	9.19	7.76	2.47	090
44346		A	Revision of colostomy	19.63	NA	NA	10.15	8.46	2.80	090
44360		A	Small bowel endoscopy	2.59	NA	NA	1.40	1.45	0.28	000
44361		A	Small bowel endoscopy/biopsy	2.87	NA	NA	1.53	1.58	0.30	000
44363		A	Small bowel endoscopy	3.49	NA	NA	1.76	1.78	0.37	000
44364		A	Small bowel endoscopy	3.73	NA	NA	1.89	1.95	0.40	000
44365		A	Small bowel endoscopy	3.31	NA	NA	1.71	1.75	0.36	000
44366		A	Small bowel endoscopy	4.40	NA	NA	2.20	2.29	0.47	000
44369		A	Small bowel endoscopy	4.51	NA	NA	2.25	2.33	0.48	000
44370		A	Small bowel endoscopy/stent	4.79	NA	NA	2.52	2.58	0.51	000
44372		A	Small bowel endoscopy	4.40	NA	NA	2.11	2.11	0.51	000
44373		A	Small bowel endoscopy	3.49	NA	NA	1.74	1.78	0.39	000
44376		A	Small bowel endoscopy	5.25	NA	NA	2.49	2.52	0.59	000
44377		A	Small bowel endoscopy/biopsy	5.52	NA	NA	2.67	2.74	0.59	000

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44378		A	Small bowel endoscopy	7.12	NA	NA	3.37	3.47	0.76	000
44379		A	S bowel endoscope w/stent	7.46	NA	NA	3.71	3.75	0.79	000
44380		A	Small bowel endoscopy	1.05	NA	NA	0.69	0.72	0.11	000
44382		A	Small bowel endoscopy	1.27	NA	NA	0.81	0.84	0.14	000
44383		A	Ileoscopy w/stent	2.94	NA	NA	1.35	1.56	0.23	000
44385		A	Endoscopy of bowel pouch	1.82	4.55	4.51	0.93	0.89	0.19	000
44386		A	Endoscopy, bowel pouch/biop	2.12	6.40	6.61	1.13	1.06	0.24	000
44388		A	Colonoscopy	2.82	5.83	5.87	1.43	1.38	0.34	000
44389		A	Colonoscopy with biopsy	3.13	6.56	6.90	1.59	1.57	0.35	000
44390		A	Colonoscopy for foreign body	3.82	7.59	7.81	1.96	1.85	0.40	000
44391		A	Colonoscopy for bleeding	4.31	7.86	8.57	2.08	2.12	0.48	000
44392		A	Colonoscopy & polypectomy	3.81	7.04	7.11	1.82	1.74	0.45	000
44393		A	Colonoscopy, lesion removal	4.83	7.62	7.80	2.28	2.23	0.55	000
44394		A	Colonoscopy w/snare	4.42	7.88	8.27	2.13	2.11	0.50	000
44397		A	Colonoscopy w/stent	4.70	NA	NA	2.33	2.35	0.50	000
44500		A	Intro, gastrointestinal tube	0.49	NA	NA	0.16	0.18	0.03	000
44602		A	Suture, small intestine	24.72	NA	NA	10.58	8.45	3.69	090
44603		A	Suture, small intestine	28.16	NA	NA	12.40	9.93	4.16	090
44604		A	Suture, large intestine	18.16	NA	NA	8.28	6.98	2.68	090
44605		A	Repair of bowel lesion	22.08	NA	NA	10.68	8.98	3.30	090
44615		A	Intestinal stricturoplasty	18.16	NA	NA	8.78	7.43	2.69	090
44620		A	Repair bowel opening	14.43	NA	NA	7.41	6.18	2.04	090
44625		A	Repair bowel opening	17.28	NA	NA	8.47	7.04	2.42	090
44626		A	Repair bowel opening	27.90	NA	NA	12.40	10.40	4.12	090
44640		A	Repair bowel-skin fistula	24.20	NA	NA	10.98	9.26	3.52	090
44650		A	Repair bowel fistula	25.12	NA	NA	11.28	9.62	3.65	090
44660		A	Repair bowel-bladder fistula	23.91	NA	NA	10.25	9.87	2.79	090
44661		A	Repair bowel-bladder fistula	27.35	NA	NA	11.95	10.53	3.69	090
44680		A	Surgical revision, intestine	17.96	NA	NA	8.83	7.38	2.77	090
44700		A	Suspend bowel w/prosthesis	17.48	NA	NA	8.47	7.11	2.18	090
44701		A	Intraop colon lavage add-on	3.10	NA	NA	1.14	0.96	0.42	ZZZ
44715		C	Prepare donor intestine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44720		A	Prep donor intestine/venous	5.00	NA	NA	1.83	1.75	0.25	XXX
44721		A	Prep donor intestine/artery	7.00	NA	NA	2.58	2.24	1.08	XXX
44799		C	Unlisted procedure intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44800		A	Excision of bowel pouch	12.05	NA	NA	7.00	6.03	1.77	090
44820		A	Excision of mesentery lesion	13.73	NA	NA	7.23	6.21	2.04	090
44850		A	Repair of mesentery	12.11	NA	NA	6.42	5.49	1.82	090
44899		C	Bowel surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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44900		A	Drain app abscess, open	12.57	NA	NA	6.70	5.62	1.91	090
44901		A	Drain app abscess, percut	3.37	18.21	21.29	1.02	1.21	0.26	000
44950		A	Appendectomy	10.60	NA	NA	5.40	4.61	1.61	090
44955		A	Appendectomy add-on	1.53	NA	NA	0.57	0.50	0.22	ZZZ
44960		A	Appendectomy	14.50	NA	NA	7.27	6.09	2.21	090
44970		A	Laparoscopy, appendectomy	9.45	NA	NA	5.49	4.65	1.43	090
44979		C	Laparoscope proc, app	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45000		A	Drainage of pelvic abscess	6.30	NA	NA	4.34	3.78	0.77	090
45005		A	Drainage of rectal abscess	2.02	4.48	4.14	1.91	1.69	0.27	010
45020		A	Drainage of rectal abscess	8.56	NA	NA	5.63	4.73	1.15	090
45100		A	Biopsy of rectum	4.04	NA	NA	3.45	2.97	0.52	090
45108		A	Removal of anorectal lesion	5.12	NA	NA	4.01	3.36	0.77	090
45110		A	Removal of rectum	30.76	NA	NA	16.08	13.50	4.21	090
45111		A	Partial removal of rectum	18.01	NA	NA	9.40	7.92	2.56	090
45112		A	Removal of rectum	33.18	NA	NA	14.76	12.27	4.40	090
45113		A	Partial proctectomy	33.22	NA	NA	16.54	13.58	5.12	090
45114		A	Partial removal of rectum	30.79	NA	NA	14.40	11.81	4.74	090
45116		A	Partial removal of rectum	27.72	NA	NA	12.88	10.64	2.86	090
45119		A	Remove rectum w/reservoir	33.48	NA	NA	16.42	13.46	4.24	090
45120		A	Removal of rectum	26.40	NA	NA	13.13	10.96	4.05	090
45121		A	Removal of rectum and colon	29.08	NA	NA	14.12	11.73	4.47	090
45123		A	Partial proctectomy	18.86	NA	NA	9.74	7.92	2.28	090
45126		A	Pelvic exenteration	49.10	NA	NA	22.11	19.98	7.56	090
45130		A	Excision of rectal prolapse	18.50	NA	NA	9.43	7.67	2.25	090
45135		A	Excision of rectal prolapse	22.36	NA	NA	11.85	9.65	3.42	090
45136		A	Excise ileoanal reservior	30.82	NA	NA	16.13	13.55	3.17	090
45150		A	Excision of rectal stricture	5.85	NA	NA	4.18	3.73	0.59	090
45160		A	Excision of rectal lesion	16.33	NA	NA	8.89	7.46	2.50	090
45171		A	Exc rect tum transanal part	8.13	NA	NA	6.90	6.90	1.06	090
45172		A	Exc rect tum transanal full	12.13	NA	NA	8.37	8.37	1.61	090
45190		A	Destruction, rectal tumor	10.42	NA	NA	7.07	5.89	1.35	090
45300		A	Proctosigmoidoscopy dx	0.80	2.21	1.97	0.58	0.47	0.09	000
45303		A	Proctosigmoidoscopy dilate	1.50	21.14	20.03	0.84	0.66	0.18	000
45305		A	Proctosigmoidoscopy w/bx	1.25	3.47	3.18	0.75	0.64	0.16	000
45307		A	Proctosigmoidoscopy fb	1.70	3.71	3.28	0.91	0.72	0.23	000
45308		A	Proctosigmoidoscopy removal	1.40	3.75	3.22	0.81	0.66	0.18	000
45309		A	Proctosigmoidoscopy removal	1.50	3.82	3.52	0.85	0.78	0.19	000
45315		A	Proctosigmoidoscopy removal	1.80	3.87	3.63	0.96	0.86	0.24	000
45317		A	Proctosigmoidoscopy bleed	2.00	3.77	3.32	1.03	0.83	0.24	000

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45320		A	Proctosigmoidoscopy ablate	1.78	3.62	3.47	0.96	0.88	0.23	000
45321		A	Proctosigmoidoscopy volvul	1.75	NA	NA	0.96	0.85	0.24	000
45327		A	Proctosigmoidoscopy w/stent	2.00	NA	NA	1.15	1.03	0.31	000
45330		A	Diagnostic sigmoidoscopy	0.96	2.44	2.47	0.65	0.62	0.11	000
45331		A	Sigmoidoscopy and biopsy	1.15	2.94	3.17	0.76	0.77	0.13	000
45332		A	Sigmoidoscopy w/fb removal	1.79	5.18	5.36	1.02	1.00	0.20	000
45333		A	Sigmoidoscopy & polypectomy	1.79	5.30	5.43	1.01	0.99	0.21	000
45334		A	Sigmoidoscopy for bleeding	2.73	NA	NA	1.44	1.48	0.29	000
45335		A	Sigmoidoscopy w/submuc inj	1.46	4.84	4.78	0.88	0.87	0.16	000
45337		A	Sigmoidoscopy & decompress	2.36	NA	NA	1.26	1.24	0.28	000
45338		A	Sigmoidoscopy w/tumr remove	2.34	5.35	5.64	1.26	1.27	0.26	000
45339		A	Sigmoidoscopy w/ablate tumr	3.14	5.17	5.17	1.61	1.62	0.35	000
45340		A	Sig w/balloon dilation	1.89	9.47	9.32	1.05	1.04	0.22	000
45341		A	Sigmoidoscopy w/ultrasound	2.60	NA	NA	1.39	1.42	0.28	000
45342		A	Sigmoidoscopy w/us guide bx	4.05	NA	NA	2.03	2.09	0.43	000
45345		A	Sigmoidoscopy w/stent	2.92	NA	NA	1.51	1.54	0.32	000
45355		A	Surgical colonoscopy	3.51	NA	NA	1.70	1.59	0.42	000
45378		A	Diagnostic colonoscopy	3.69	5.90	6.26	1.83	1.82	0.42	000
45378	53	A	Diagnostic colonoscopy	0.96	2.44	2.47	0.65	0.62	0.11	000
45379		A	Colonoscopy w/fb removal	4.68	7.61	7.97	2.25	2.22	0.53	000
45380		A	Colonoscopy and biopsy	4.43	6.99	7.50	2.17	2.21	0.49	000
45381		A	Colonoscopy, submucous inj	4.19	6.89	7.43	2.07	2.11	0.45	000
45382		A	Colonoscopy/control bleeding	5.68	9.14	10.01	2.73	2.81	0.61	000
45383		A	Lesion removal colonoscopy	5.86	8.08	8.37	2.71	2.67	0.67	000
45384		A	Lesion remove colonoscopy	4.69	6.76	7.06	2.23	2.21	0.54	000
45385		A	Lesion removal colonoscopy	5.30	7.60	8.13	2.54	2.58	0.58	000
45386		A	Colonoscopy dilate stricture	4.57	11.26	12.10	2.19	2.19	0.52	000
45387		A	Colonoscopy w/stent	5.90	NA	NA	2.91	2.93	0.65	000
45391		A	Colonoscopy w/endoscope us	5.09	NA	NA	2.46	2.52	0.54	000
45392		A	Colonoscopy w/endoscopic fnb	6.54	NA	NA	3.08	3.15	0.73	000
45395		A	Lap, removal of rectum	33.00	NA	NA	17.69	14.87	4.31	090
45397		A	Lap, remove rectum w/pouch	36.50	NA	NA	18.73	15.53	4.34	090
45400		A	Laparoscopic proc	19.44	NA	NA	9.84	8.22	2.57	090
45402		A	Lap proctopexy w/sig resect	26.51	NA	NA	12.50	10.35	3.46	090
45499		C	Laparoscope proc, rectum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45500		A	Repair of rectum	7.73	NA	NA	5.60	4.68	0.86	090
45505		A	Repair of rectum	8.36	NA	NA	6.47	5.33	1.07	090
45520		A	Treatment of rectal prolapse	0.55	3.21	2.74	0.48	0.41	0.06	000
45540		A	Correct rectal prolapse	18.12	NA	NA	8.87	7.39	2.25	090

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45541		A	Correct rectal prolapse	14.85	NA	NA	8.73	7.25	1.87	090
45550		A	Repair rectum/remove sigmoid	24.80	NA	NA	12.51	10.29	3.22	090
45560		A	Repair of rectocele	11.50	NA	NA	6.33	5.82	1.28	090
45562		A	Exploration/repair of rectum	17.98	NA	NA	10.04	8.71	2.42	090
45563		A	Exploration/repair of rectum	26.38	NA	NA	14.49	12.05	4.05	090
45800		A	Repair rect/bladder fistula	20.31	NA	NA	9.97	9.42	2.44	090
45805		A	Repair fistula w/colostomy	23.32	NA	NA	12.94	10.80	3.58	090
45820		A	Repair rectourethral fistula	20.37	NA	NA	9.05	9.12	1.43	090
45825		A	Repair fistula w/colostomy	24.17	NA	NA	13.68	11.74	2.49	090
45900		A	Reduction of rectal prolapse	2.99	NA	NA	2.08	1.78	0.40	010
45905		A	Dilation of anal sphincter	2.35	NA	NA	1.89	1.69	0.30	010
45910		A	Dilation of rectal narrowing	2.85	NA	NA	2.05	1.90	0.34	010
45915		A	Remove rectal obstruction	3.19	4.76	4.41	2.43	2.18	0.38	010
45990		A	Surg dx exam, anorectal	1.80	NA	NA	0.94	0.83	0.23	000
45999		C	Rectum surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
46020		A	Placement of seton	3.00	3.84	3.23	2.87	2.41	0.39	010
46030		A	Removal of rectal marker	1.26	2.17	1.88	1.01	0.86	0.16	010
46040		A	Incision of rectal abscess	5.37	7.68	6.72	4.88	4.22	0.74	090
46045		A	Incision of rectal abscess	5.87	NA	NA	4.90	4.07	0.82	090
46050		A	Incision of anal abscess	1.24	3.66	3.20	1.20	1.02	0.16	010
46060		A	Incision of rectal abscess	6.37	NA	NA	5.50	4.58	0.83	090
46070		A	Incision of anal septum	2.79	NA	NA	2.84	2.68	0.14	090
46080		A	Incision of anal sphincter	2.52	3.60	3.11	1.48	1.25	0.35	010
46083		A	Incise external hemorrhoid	1.45	2.80	2.78	1.23	1.13	0.18	010
46200		A	Removal of anal fissure	3.59	7.27	6.14	4.48	3.81	0.44	090
46220		A	Excise anal ext tag/papilla	1.61	3.44	3.03	1.37	1.17	0.21	010
46221		A	Ligation of hemorrhoid(s)	2.36	4.26	3.71	2.40	2.09	0.29	010
46230		A	Removal of anal tags	2.62	4.13	3.63	1.73	1.47	0.34	010
46250		A	Remove ext hem groups = 2	4.25	7.02	6.21	3.55	3.05	0.58	090
46255		A	Remove int/ext hem 1 group	4.96	7.43	6.62	3.85	3.30	0.68	090
46257		A	Remove in/ex hem grp & fiss	5.76	NA	NA	4.81	3.98	0.76	090
46258		A	Remove in/ex hem grp w/fistu	6.41	NA	NA	5.20	4.30	0.96	090
46260		A	Remove in/ex hem groups = 2	6.73	NA	NA	5.13	4.27	0.90	090
46261		A	Remove in/ex hem grps & fiss	7.76	NA	NA	5.54	4.60	0.99	090
46262		A	Remove in/ex hem grps w/fist	7.91	NA	NA	5.97	4.98	1.01	090
46270		A	Remove anal fist subq	4.92	7.50	6.48	4.79	4.01	0.68	090
46275		A	Remove anal fist inter	5.42	7.83	6.65	4.93	4.11	0.68	090
46280		A	Remove anal fist complex	6.39	NA	NA	5.36	4.45	0.79	090
46285		A	Remove anal fist 2 stage	5.42	7.76	6.42	4.94	4.06	0.65	090

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46288		A	Repair anal fistula	7.81	NA	NA	5.98	4.97	0.96	090
46320		A	Removal of hemorrhoid clot	1.64	2.86	2.50	1.15	0.97	0.21	010
46500		A	Injection into hemorrhoid(s)	1.69	4.13	3.50	1.57	1.34	0.19	010
46505		A	Chemodenervation anal musc	3.18	3.93	3.46	2.83	2.42	0.41	010
46600		A	Diagnostic anoscopy	0.55	1.58	1.48	0.48	0.40	0.06	000
46604		A	Anoscopy and dilation	1.03	13.61	12.10	0.66	0.58	0.12	000
46606		A	Anoscopy and biopsy	1.20	4.24	4.01	0.73	0.61	0.16	000
46608		A	Anoscopy, remove for body	1.30	4.34	4.05	0.70	0.64	0.17	000
46610		A	Anoscopy, remove lesion	1.28	4.22	3.99	0.77	0.66	0.18	000
46611		A	Anoscopy	1.30	2.93	2.79	0.76	0.67	0.16	000
46612		A	Anoscopy, remove lesions	1.50	4.92	4.73	0.86	0.79	0.23	000
46614		A	Anoscopy, control bleeding	1.00	2.14	2.08	0.65	0.63	0.11	000
46615		A	Anoscopy	1.50	2.00	1.97	0.84	0.79	0.21	000
46700		A	Repair of anal stricture	9.81	NA	NA	6.74	5.53	1.17	090
46705		A	Repair of anal stricture	7.43	NA	NA	5.23	4.93	0.37	090
46706		A	Repr of anal fistula w/glue	2.44	NA	NA	1.79	1.57	0.31	010
46707		A	Repair anorectal fist w/plug	6.39	NA	NA	5.27	5.27	0.65	090
46710		A	Repr per/vag pouch sngl proc	17.14	NA	NA	10.23	8.81	2.63	090
46712		A	Repr per/vag pouch dbl proc	36.45	NA	NA	17.32	15.38	1.84	090
46715		A	Rep perf anoper fistu	7.62	NA	NA	4.92	4.56	0.38	090
46716		A	Rep perf anoper/vestib fistu	17.54	NA	NA	10.72	12.18	0.86	090
46730		A	Construction of absent anus	30.65	NA	NA	24.85	17.31	1.52	090
46735		A	Construction of absent anus	36.14	NA	NA	18.11	16.95	1.81	090
46740		A	Construction of absent anus	33.90	NA	NA	19.21	15.99	5.17	090
46742		A	Repair of imperforated anus	40.14	NA	NA	21.43	18.27	6.13	090
46744		A	Repair of cloacal anomaly	58.94	NA	NA	27.63	22.92	6.06	090
46746		A	Repair of cloacal anomaly	65.44	NA	NA	28.92	27.60	3.27	090
46748		A	Repair of cloacal anomaly	71.42	NA	NA	31.10	29.01	3.57	090
46750		A	Repair of anal sphincter	12.15	NA	NA	7.29	6.25	1.42	090
46751		A	Repair of anal sphincter	9.30	NA	NA	5.72	5.71	1.12	090
46753		A	Reconstruction of anus	8.89	NA	NA	5.90	4.97	1.07	090
46754		A	Removal of suture from anus	3.01	4.33	3.92	2.81	2.35	0.30	010
46760		A	Repair of anal sphincter	17.45	NA	NA	10.64	8.74	1.79	090
46761		A	Repair of anal sphincter	15.29	NA	NA	8.64	7.17	1.75	090
46762		A	Implant artificial sphincter	14.82	NA	NA	8.89	7.48	1.52	090
46900		A	Destruction, anal lesion(s)	1.91	4.04	3.62	1.60	1.42	0.22	010
46910		A	Destruction, anal lesion(s)	1.91	4.34	3.89	1.49	1.29	0.24	010
46916		A	Cryosurgery, anal lesion(s)	1.91	3.79	3.75	1.77	1.66	0.19	010
46917		A	Laser surgery, anal lesions	1.91	9.14	9.03	1.44	1.29	0.23	010

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46922		A	Excision of anal lesion(s)	1.91	4.62	4.13	1.49	1.28	0.25	010
46924		A	Destruction, anal lesion(s)	2.81	10.27	9.69	1.90	1.64	0.33	010
46930		A	Destroy internal hemorrhoids	1.61	3.30	3.54	2.00	2.10	0.08	090
46940		A	Treatment of anal fissure	2.35	3.34	2.85	1.40	1.18	0.27	010
46942		A	Treatment of anal fissure	2.07	3.31	2.79	1.30	1.08	0.23	010
46945		A	Remove by ligat int hem grp	2.21	5.26	4.65	3.35	3.00	0.27	090
46946		A	Remove by ligat int hem grps	2.63	4.93	4.58	2.92	2.71	0.32	090
46947		A	Hemorrhoidopexy by stapling	5.57	NA	NA	3.98	3.35	0.77	090
46999		C	Anus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47000		A	Needle biopsy of liver	1.90	6.90	6.69	0.60	0.71	0.14	000
47001		A	Needle biopsy, liver add-on	1.90	NA	NA	0.69	0.60	0.28	ZZZ
47010		A	Open drainage, liver lesion	19.40	NA	NA	10.41	9.16	2.85	090
47011		A	Percut drain, liver lesion	3.69	NA	NA	1.11	1.36	0.26	000
47015		A	Inject/aspirate liver cyst	18.50	NA	NA	10.35	8.68	2.84	090
47100		A	Wedge biopsy of liver	12.91	NA	NA	8.08	6.92	1.94	090
47120		A	Partial removal of liver	39.01	NA	NA	18.94	16.12	5.96	090
47122		A	Extensive removal of liver	59.48	NA	NA	25.96	22.05	9.15	090
47125		A	Partial removal of liver	53.04	NA	NA	23.55	20.01	8.11	090
47130		A	Partial removal of liver	57.19	NA	NA	24.91	21.28	8.73	090
47133		X	Removal of donor liver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47135		R	Transplantation of liver	83.64	NA	NA	38.04	32.35	12.80	090
47136		R	Transplantation of liver	70.74	NA	NA	33.52	28.39	10.88	090
47140		A	Partial removal, donor liver	59.40	NA	NA	29.23	24.60	9.16	090
47141		A	Partial removal, donor liver	71.50	NA	NA	32.09	28.46	3.59	090
47142		A	Partial removal, donor liver	79.44	NA	NA	37.37	31.54	12.25	090
47143		C	Prep donor liver, whole	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47144		C	Prep donor liver, 3-segment	0.00	0.00	0.00	0.00	0.00	0.00	090
47145		C	Prep donor liver, lobe split	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47146		A	Prep donor liver/venous	6.00	NA	NA	2.21	1.89	0.92	XXX
47147		A	Prep donor liver/arterial	7.00	NA	NA	2.58	2.20	1.06	XXX
47300		A	Surgery for liver lesion	18.14	NA	NA	10.12	8.48	2.76	090
47350		A	Repair liver wound	22.49	NA	NA	11.65	9.94	3.38	090
47360		A	Repair liver wound	31.31	NA	NA	14.85	12.76	4.82	090
47361		A	Repair liver wound	52.60	NA	NA	22.68	19.43	7.73	090
47362		A	Repair liver wound	23.54	NA	NA	12.30	10.29	3.55	090
47370		A	Laparo ablate liver tumor rf	20.80	NA	NA	10.10	8.68	3.05	090
47371		A	Laparo ablate liver cryosurg	20.80	NA	NA	10.40	9.16	3.20	090
47379		C	Laparoscope procedure, liver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47380		A	Open ablate liver tumor rf	24.56	NA	NA	11.36	9.89	3.56	090

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47381		A	Open ablate liver tumor cryo	24.88	NA	NA	11.90	10.35	3.82	090
47382		A	Percut ablate liver rf	15.22	102.11	31.02	5.05	6.35	1.06	010
47399		C	Liver surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47400		A	Incision of liver duct	36.36	NA	NA	17.18	14.50	5.61	090
47420		A	Incision of bile duct	22.03	NA	NA	11.34	9.65	3.37	090
47425		A	Incision of bile duct	22.31	NA	NA	11.62	9.76	3.43	090
47460		A	Incise bile duct sphincter	20.52	NA	NA	11.11	9.81	3.16	090
47480		A	Incision of gallbladder	13.25	NA	NA	8.38	7.17	1.98	090
47490		A	Incision of gallbladder	8.13	NA	NA	4.58	5.43	0.55	090
47500		A	Injection for liver x-rays	1.96	NA	NA	0.58	0.72	0.14	000
47505		A	Injection for liver x-rays	0.76	NA	NA	0.23	0.28	0.05	000
47510		A	Insert catheter, bile duct	8.03	NA	NA	4.01	4.79	0.57	090
47511		A	Insert bile duct drain	10.77	NA	NA	4.23	5.19	0.73	090
47525		A	Change bile duct catheter	1.54	10.47	11.80	0.67	1.20	0.10	000
47530		A	Revise/reinsert bile tube	6.05	28.06	31.11	2.99	3.58	0.43	090
47550		A	Bile duct endoscopy add-on	3.02	NA	NA	1.12	0.97	0.45	ZZZ
47552		A	Biliary endoscopy thru skin	6.03	NA	NA	2.16	2.59	0.45	000
47553		A	Biliary endoscopy thru skin	6.34	NA	NA	1.91	2.31	0.45	000
47554		A	Biliary endoscopy thru skin	9.05	NA	NA	3.40	3.50	1.09	000
47555		A	Biliary endoscopy thru skin	7.55	NA	NA	2.19	2.78	0.52	000
47556		A	Biliary endoscopy thru skin	8.55	NA	NA	2.52	3.16	0.58	000
47560		A	Laparoscopy w/cholangio	4.88	NA	NA	1.80	1.56	0.75	000
47561		A	Laparo w/cholangio/biopsy	5.17	NA	NA	2.16	1.87	0.79	000
47562		A	Laparoscopic cholecystectomy	11.76	NA	NA	6.89	5.81	1.79	090
47563		A	Laparo cholecystectomy/graph	12.11	NA	NA	6.71	5.72	1.86	090
47564		A	Laparo cholecystectomy/explr	14.24	NA	NA	7.24	6.20	2.19	090
47570		A	Laparo cholecystoenterostomy	12.56	NA	NA	6.68	5.71	1.95	090
47579		C	Laparoscope proc, biliary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47600		A	Removal of gallbladder	17.48	NA	NA	9.52	7.86	2.66	090
47605		A	Removal of gallbladder	15.98	NA	NA	8.45	7.17	2.45	090
47610		A	Removal of gallbladder	20.92	NA	NA	10.32	8.71	3.21	090
47612		A	Removal of gallbladder	21.21	NA	NA	10.32	8.73	3.26	090
47620		A	Removal of gallbladder	23.07	NA	NA	11.04	9.37	3.55	090
47630		A	Remove bile duct stone	9.65	NA	NA	4.37	4.94	0.86	090
47700		A	Exploration of bile ducts	16.50	NA	NA	9.60	8.25	2.54	090
47701		A	Bile duct revision	28.73	NA	NA	14.35	13.26	4.43	090
47711		A	Excision of bile duct tumor	25.90	NA	NA	12.81	10.91	3.96	090
47712		A	Excision of bile duct tumor	33.72	NA	NA	15.96	13.39	5.20	090
47715		A	Excision of bile duct cyst	21.55	NA	NA	11.47	9.57	3.31	090

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47720		A	Fuse gallbladder & bowel	18.34	NA	NA	10.30	8.62	2.80	090
47721		A	Fuse upper gi structures	21.99	NA	NA	11.63	9.73	3.38	090
47740		A	Fuse gallbladder & bowel	21.23	NA	NA	11.35	9.46	3.26	090
47741		A	Fuse gallbladder & bowel	24.21	NA	NA	12.45	10.43	3.72	090
47760		A	Fuse bile ducts and bowel	38.32	NA	NA	17.81	14.43	5.85	090
47765		A	Fuse liver ducts & bowel	52.19	NA	NA	23.39	18.34	8.04	090
47780		A	Fuse bile ducts and bowel	42.32	NA	NA	19.30	15.52	6.49	090
47785		A	Fuse bile ducts and bowel	56.19	NA	NA	24.70	19.52	8.68	090
47800		A	Reconstruction of bile ducts	26.17	NA	NA	13.07	11.04	4.02	090
47801		A	Placement, bile duct support	17.60	NA	NA	8.15	8.78	1.77	090
47802		A	Fuse liver duct & intestine	24.93	NA	NA	12.97	10.91	3.83	090
47900		A	Suture bile duct injury	22.44	NA	NA	11.65	9.82	3.40	090
47999		C	Bile tract surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
48000		A	Drainage of abdomen	31.95	NA	NA	14.26	12.53	4.47	090
48001		A	Placement of drain, pancreas	39.69	NA	NA	17.73	14.90	6.12	090
48020		A	Removal of pancreatic stone	19.09	NA	NA	10.14	8.59	2.93	090
48100		A	Biopsy of pancreas, open	14.46	NA	NA	7.59	6.50	2.16	090
48102		A	Needle biopsy, pancreas	4.70	8.55	9.25	1.60	1.98	0.32	010
48105		A	Resect/debride pancreas	49.26	NA	NA	21.87	18.26	7.43	090
48120		A	Removal of pancreas lesion	18.41	NA	NA	9.15	7.72	2.82	090
48140		A	Partial removal of pancreas	26.32	NA	NA	12.58	10.62	4.02	090
48145		A	Partial removal of pancreas	27.39	NA	NA	13.20	10.99	4.22	090
48146		A	Pancreatectomy	30.60	NA	NA	15.70	13.31	4.70	090
48148		A	Removal of pancreatic duct	20.39	NA	NA	10.61	8.85	3.13	090
48150		A	Partial removal of pancreas	52.84	NA	NA	24.45	20.75	8.12	090
48152		A	Pancreatectomy	48.65	NA	NA	23.09	19.48	7.50	090
48153		A	Pancreatectomy	52.79	NA	NA	24.37	20.67	8.11	090
48154		A	Pancreatectomy	48.88	NA	NA	23.18	19.44	7.53	090
48155		A	Removal of pancreas	29.45	NA	NA	15.57	13.24	4.53	090
48160		N	Pancreas removal/transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48400		A	Injection, intraop add-on	1.95	NA	NA	0.87	0.76	0.21	ZZZ
48500		A	Surgery of pancreatic cyst	18.16	NA	NA	10.40	8.71	2.79	090
48510		A	Drain pancreatic pseudocyst	17.19	NA	NA	9.79	8.35	2.59	090
48511		A	Drain pancreatic pseudocyst	3.99	18.32	20.24	1.19	1.47	0.28	000
48520		A	Fuse pancreas cyst and bowel	18.15	NA	NA	9.07	7.68	2.78	090
48540		A	Fuse pancreas cyst and bowel	21.94	NA	NA	10.63	8.85	3.38	090
48545		A	Pancreatorrhaphy	22.23	NA	NA	11.19	9.23	3.42	090
48547		A	Duodenal exclusion	30.38	NA	NA	14.19	11.77	4.68	090
48548		A	Fuse pancreas and bowel	28.09	NA	NA	13.19	11.25	4.31	090

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48550		X	Donor pancreatectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48551		C	Prep donor pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48552		A	Prep donor pancreas/venous	4.30	NA	NA	1.59	1.39	0.66	XXX
48554		R	Transpl allograft pancreas	37.80	NA	NA	25.75	22.09	5.61	090
48556		A	Removal, allograft pancreas	19.47	NA	NA	12.13	10.23	2.98	090
48999		C	Pancreas surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49000		A	Exploration of abdomen	12.54	NA	NA	6.69	5.83	1.86	090
49002		A	Reopening of abdomen	17.63	NA	NA	8.49	6.93	2.63	090
49010		A	Exploration behind abdomen	16.06	NA	NA	7.48	6.77	2.31	090
49020		A	Drain abdominal abscess	26.67	NA	NA	13.05	11.17	3.89	090
49021		A	Drain abdominal abscess	3.37	17.80	19.77	1.01	1.24	0.23	000
49040		A	Drain, open, abdom abscess	16.52	NA	NA	8.47	7.26	2.43	090
49041		A	Drain, percut, abdom abscess	3.99	17.94	19.68	1.19	1.46	0.27	000
49060		A	Drain, open, retrop abscess	18.53	NA	NA	8.93	8.02	2.65	090
49061		A	Drain, percut, retroper absc	3.69	17.85	19.58	1.10	1.35	0.25	000
49062		A	Drain to peritoneal cavity	12.22	NA	NA	6.13	5.68	1.80	090
49080		A	Puncture, peritoneal cavity	1.35	2.51	2.96	0.44	0.50	0.10	000
49081		A	Removal of abdominal fluid	1.26	2.79	2.87	0.46	0.48	0.12	000
49180		A	Biopsy, abdominal mass	1.73	2.21	2.60	0.52	0.64	0.12	000
49203		A	Exc abd tum 5 cm or less	20.13	NA	NA	9.81	8.62	2.84	090
49204		A	Exc abd tum over 5 cm	26.13	NA	NA	12.02	10.50	3.66	090
49205		A	Exc abd tum over 10 cm	30.13	NA	NA	13.57	11.78	4.35	090
49215		A	Excise sacral spine tumor	37.81	NA	NA	16.99	14.67	5.45	090
49220		A	Multiple surgery, abdomen	15.79	NA	NA	8.30	7.15	2.43	090
49250		A	Excision of umbilicus	9.01	NA	NA	5.44	4.77	1.31	090
49255		A	Removal of omentum	12.56	NA	NA	7.13	6.20	1.82	090
49320		A	Diag laparo separate proc	5.14	NA	NA	3.03	2.71	0.73	010
49321		A	Laparoscopy, biopsy	5.44	NA	NA	3.21	2.83	0.79	010
49322		A	Laparoscopy, aspiration	6.01	NA	NA	3.28	2.97	0.82	010
49323		A	Laparo drain lymphocele	10.23	NA	NA	5.61	5.05	1.53	090
49324		A	Lap insertion perm ip cath	6.32	NA	NA	3.54	3.07	0.96	010
49325		A	Lap revision perm ip cath	6.82	NA	NA	3.70	3.21	1.05	010
49326		A	Lap w/omentopexy add-on	3.50	NA	NA	1.26	1.05	0.54	ZZZ
49329		C	Laparo proc, abdm/per/oment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49400		A	Air injection into abdomen	1.88	2.36	2.64	0.59	0.67	0.17	000
49402		A	Remove foreign body, adbomen	14.09	NA	NA	7.21	6.19	2.09	090
49411		A	Ins mark abd/pel for rt perq	3.82	9.91	9.91	1.42	1.42	0.26	000
49419		A	Insrt abdom cath for chemotx	7.08	NA	NA	4.00	3.75	0.88	090
49420		A	Insert abdom drain, temp	2.22	NA	NA	1.18	1.20	0.25	000

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49421		A	Insert abdom drain, perm	5.90	NA	NA	3.67	3.37	0.84	090
49422		A	Remove perm cannula/catheter	6.29	NA	NA	3.28	2.95	0.94	010
49423		A	Exchange drainage catheter	1.46	11.97	13.22	0.46	0.57	0.10	000
49424		A	Assess cyst, contrast inject	0.76	2.81	3.19	0.25	0.31	0.05	000
49425		A	Insert abdomen-venous drain	12.22	NA	NA	6.44	5.88	1.93	090
49426		A	Revise abdomen-venous shunt	10.41	NA	NA	5.41	5.00	1.50	090
49427		A	Injection, abdominal shunt	0.89	NA	NA	0.28	0.33	0.08	000
49428		A	Ligation of shunt	6.87	NA	NA	3.85	3.58	1.04	010
49429		A	Removal of shunt	7.44	NA	NA	3.60	3.39	1.15	010
49435		A	Insert subq exten to ip cath	2.25	NA	NA	0.76	0.65	0.34	ZZZ
49436		A	Embedded ip cath exit-site	2.72	NA	NA	1.93	1.72	0.41	010
49440		A	Place gastrostomy tube perc	4.18	21.33	24.04	1.66	1.88	0.34	010
49441		A	Place duod/jej tube perc	4.77	22.91	25.99	1.84	2.08	0.40	010
49442		A	Place cecostomy tube perc	4.00	18.28	22.94	1.64	1.71	0.27	010
49446		A	Change g-tube to g-j perc	3.31	20.47	22.64	0.99	1.23	0.23	000
49450		A	Replace g/c tube perc	1.36	14.56	17.63	0.42	0.47	0.10	000
49451		A	Replace duod/jej tube perc	1.84	15.46	16.76	0.57	0.69	0.14	000
49452		A	Replace g-j tube perc	2.86	18.51	20.42	0.86	1.07	0.20	000
49460		A	Fix g/colon tube w/device	0.96	16.40	19.87	0.30	0.34	0.08	000
49465		A	Fluoro exam of g/colon tube	0.62	3.49	3.84	0.19	0.23	0.04	000
49491		A	Rpr hern preemie reduc	12.53	NA	NA	7.13	5.98	1.93	090
49492		A	Rpr ing hern premie, blocked	15.43	NA	NA	6.60	6.60	2.37	090
49495		A	Rpr ing hernia baby, reduc	6.20	NA	NA	3.95	3.24	0.94	090
49496		A	Rpr ing hernia baby, blocked	9.42	NA	NA	5.78	4.89	1.58	090
49500		A	Rpr ing hernia, init, reduce	5.84	NA	NA	4.33	3.62	0.88	090
49501		A	Rpr ing hernia, init blocked	9.36	NA	NA	5.63	4.78	1.44	090
49505		A	Prp i/hern init reduc >5 yr	7.96	NA	NA	4.97	4.26	1.19	090
49507		A	Prp i/hern init block >5 yr	10.05	NA	NA	5.79	4.95	1.52	090
49520		A	Rerepair ing hernia, reduce	9.99	NA	NA	5.70	4.88	1.52	090
49521		A	Rerepair ing hernia, blocked	12.44	NA	NA	6.57	5.63	1.89	090
49525		A	Repair ing hernia, sliding	8.93	NA	NA	5.31	4.55	1.34	090
49540		A	Repair lumbar hernia	10.74	NA	NA	6.06	5.16	1.63	090
49550		A	Rpr rem hernia, init, reduce	8.99	NA	NA	5.32	4.55	1.36	090
49553		A	Rpr fem hernia, init blocked	9.92	NA	NA	5.76	4.90	1.51	090
49555		A	Rerepair fem hernia, reduce	9.39	NA	NA	5.52	4.70	1.43	090
49557		A	Rerepair fem hernia, blocked	11.62	NA	NA	6.39	5.45	1.78	090
49560		A	Rpr ventral hern init, reduc	11.92	NA	NA	6.43	5.50	1.81	090
49561		A	Rpr ventral hern init, block	15.38	NA	NA	7.76	6.58	2.34	090
49565		A	Rerepair ventrl hern, reduce	12.37	NA	NA	6.73	5.74	1.88	090

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49566		A	Rerepair ventrl hern, block	15.53	NA	NA	7.84	6.65	2.37	090
49568		A	Hernia repair w/mesh	4.88	NA	NA	1.80	1.54	0.74	ZZZ
49570		A	Rpr epigastric hern, reduce	6.05	NA	NA	4.26	3.65	0.91	090
49572		A	Rpr epigastric hern, blocked	7.87	NA	NA	4.91	4.15	1.19	090
49580		A	Rpr umbil hern, reduc < 5 yr	4.47	NA	NA	4.79	3.44	0.67	090
49582		A	Rpr umbil hern, block < 5 yr	7.13	NA	NA	4.81	4.07	1.08	090
49585		A	Rpr umbil hern, reduc > 5 yr	6.59	NA	NA	4.44	3.81	0.98	090
49587		A	Rpr umbil hern, block > 5 yr	8.04	NA	NA	4.98	4.25	1.21	090
49590		A	Repair spigelian hernia	8.90	NA	NA	5.30	4.53	1.34	090
49600		A	Repair umbilical lesion	11.55	NA	NA	6.55	5.78	1.78	090
49605		A	Repair umbilical lesion	87.09	NA	NA	35.71	31.44	13.43	090
49606		A	Repair umbilical lesion	19.00	NA	NA	9.12	7.79	2.93	090
49610		A	Repair umbilical lesion	10.91	NA	NA	6.13	5.34	1.68	090
49611		A	Repair umbilical lesion	9.34	NA	NA	5.05	5.17	0.46	090
49650		A	Lap ing hernia repair init	6.36	NA	NA	4.27	3.66	0.96	090
49651		A	Lap ing hernia repair recur	8.38	NA	NA	5.45	4.63	1.26	090
49652		A	Lap vent/abd hernia repair	12.88	NA	NA	6.96	5.91	0.64	090
49653		A	Lap vent/abd hern proc comp	16.21	NA	NA	8.62	7.31	0.81	090
49654		A	Lap inc hernia repair	15.03	NA	NA	7.75	6.56	0.75	090
49655		A	Lap inc hern repair comp	18.11	NA	NA	9.32	7.88	0.90	090
49656		A	Lap inc hernia repair recur	15.08	NA	NA	7.77	6.57	0.75	090
49657		A	Lap inc hern recur comp	22.11	NA	NA	10.79	9.09	1.10	090
49659		C	Laparo proc, hernia repair	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49900		A	Repair of abdominal wall	12.41	NA	NA	7.93	6.90	1.83	090
49904		A	Omental flap, extra-abdom	22.35	NA	NA	13.49	13.24	3.41	090
49905		A	Omental flap, intra-abdom	6.54	NA	NA	2.37	2.08	0.89	ZZZ
49906		C	Free omental flap, microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
49999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50010		A	Exploration of kidney	12.28	NA	NA	6.37	6.64	1.28	090
50020		A	Renal abscess, open drain	18.08	NA	NA	8.93	8.98	1.75	090
50021		A	Renal abscess, percut drain	3.37	19.02	21.02	1.00	1.23	0.23	000
50040		A	Drainage of kidney	16.68	NA	NA	7.38	8.61	1.21	090
50045		A	Exploration of kidney	16.82	NA	NA	7.49	8.58	1.17	090
50060		A	Removal of kidney stone	20.95	NA	NA	8.85	10.34	1.47	090
50065		A	Incision of kidney	22.32	NA	NA	9.30	10.55	1.56	090
50070		A	Incision of kidney	21.85	NA	NA	9.15	10.80	1.53	090
50075		A	Removal of kidney stone	27.09	NA	NA	11.06	13.02	1.90	090
50080		A	Removal of kidney stone	15.74	NA	NA	6.95	8.16	1.11	090
50081		A	Removal of kidney stone	23.50	NA	NA	9.90	11.60	1.68	090

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50100		A	Revise kidney blood vessels	17.45	NA	NA	9.30	8.25	2.68	090
50120		A	Exploration of kidney	17.21	NA	NA	7.57	8.70	1.19	090
50125		A	Explore and drain kidney	17.82	NA	NA	9.44	9.29	1.24	090
50130		A	Removal of kidney stone	18.82	NA	NA	8.15	9.54	1.31	090
50135		A	Exploration of kidney	20.59	NA	NA	8.73	10.14	1.44	090
50200		A	Renal biopsy perq	2.63	12.11	4.05	1.08	1.24	0.22	000
50205		A	Renal biopsy open	12.29	NA	NA	6.48	5.87	1.74	090
5020F		I	Txmnts 2 main Dr by 1 mon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50220		A	Remove kidney, open	18.68	NA	NA	8.32	9.28	1.62	090
50225		A	Removal kidney open, complex	21.88	NA	NA	9.36	10.50	1.73	090
50230		A	Removal kidney open, radical	23.81	NA	NA	9.68	11.21	1.79	090
50234		A	Removal of kidney & ureter	24.05	NA	NA	9.96	11.52	1.78	090
50236		A	Removal of kidney & ureter	26.94	NA	NA	11.40	13.33	1.91	090
50240		A	Partial removal of kidney	24.21	NA	NA	10.38	12.03	1.76	090
50250		A	Cryoablate renal mass open	22.22	NA	NA	9.70	11.38	1.57	090
50280		A	Removal of kidney lesion	17.09	NA	NA	7.70	8.75	1.34	090
50290		A	Removal of kidney lesion	16.15	NA	NA	7.27	7.67	1.12	090
50300		X	Remove cadaver donor kidney	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50320		A	Remove kidney, living donor	22.43	NA	NA	13.41	12.90	2.80	090
50323		C	Prep cadaver renal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50325		C	Prep donor renal graft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50327		A	Prep renal graft/venous	4.00	NA	NA	1.44	1.30	0.57	XXX
50328		A	Prep renal graft/arterial	3.50	NA	NA	1.25	1.15	0.48	XXX
50329		A	Prep renal graft/ureteral	3.34	NA	NA	1.15	1.21	0.34	XXX
50340		A	Removal of kidney	14.04	NA	NA	9.42	8.05	2.15	090
50360		A	Transplantation of kidney	40.90	NA	NA	23.12	19.86	5.95	090
50365		A	Transplantation of kidney	46.13	NA	NA	24.79	21.90	7.07	090
50370		A	Remove transplanted kidney	18.88	NA	NA	10.95	9.55	2.69	090
50380		A	Reimplantation of kidney	30.11	NA	NA	19.46	18.08	4.59	090
50382		A	Change ureter stent, percut	5.50	23.62	28.17	1.70	2.10	0.38	000
50384		A	Remove ureter stent, percut	5.00	18.68	23.60	1.55	1.92	0.34	000
50385		A	Change stent via transureth	4.44	24.05	28.56	1.61	2.05	0.31	000
50386		A	Remove stent via transureth	3.30	15.47	18.15	1.29	1.61	0.23	000
50387		A	Change ext/int ureter stent	2.00	11.39	13.59	0.59	0.75	0.14	000
50389		A	Remove renal tube w/fluoro	1.10	5.99	7.77	0.33	0.41	0.07	000
50390		A	Drainage of kidney lesion	1.96	NA	NA	0.58	0.72	0.13	000
50391		A	Instll rx agnt into rnal tub	1.96	1.26	1.49	0.70	0.78	0.14	000
50392		A	Insert kidney drain	3.37	NA	NA	1.27	1.56	0.23	000
50393		A	Insert ureteral tube	4.15	NA	NA	1.50	1.85	0.28	000

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50394		A	Injection for kidney x-ray	0.76	1.67	2.02	0.50	0.60	0.05	000
50395		A	Create passage to kidney	3.37	NA	NA	1.30	1.59	0.23	000
50396		A	Measure kidney pressure	2.09	NA	NA	0.88	1.11	0.14	000
50398		A	Change kidney tube	1.46	10.76	12.60	0.47	0.58	0.10	000
50400		A	Revision of kidney/ureter	21.27	NA	NA	8.98	10.36	1.52	090
50405		A	Revision of kidney/ureter	25.86	NA	NA	10.66	12.40	1.82	090
50500		A	Repair of kidney wound	21.22	NA	NA	10.26	9.59	3.26	090
50520		A	Close kidney-skin fistula	18.88	NA	NA	8.17	9.35	1.31	090
50525		A	Repair renal-abdomen fistula	24.39	NA	NA	12.05	11.54	3.74	090
50526		A	Repair renal-abdomen fistula	26.31	NA	NA	11.88	11.26	1.31	090
50540		A	Revision of horseshoe kidney	21.10	NA	NA	8.90	9.96	1.48	090
50541		A	Laparo ablate renal cyst	16.86	NA	NA	7.21	8.35	1.23	090
50542		A	Laparo ablate renal mass	21.36	NA	NA	9.18	10.68	1.52	090
50543		A	Laparo partial nephrectomy	27.41	NA	NA	11.58	13.46	1.97	090
50544		A	Laparoscopy, pyeloplasty	23.37	NA	NA	9.32	10.92	1.70	090
50545		A	Laparo radical nephrectomy	25.06	NA	NA	10.09	11.78	1.84	090
50546		A	Laparoscopic nephrectomy	21.87	NA	NA	9.47	10.87	1.66	090
50547		A	Laparo removal donor kidney	26.34	NA	NA	13.92	13.09	3.48	090
50548		A	Laparo remove w/ureter	25.36	NA	NA	10.00	11.73	1.82	090
50549		C	Laparoscope proc, renal	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50551		A	Kidney endoscopy	5.59	3.62	4.42	2.16	2.55	0.40	000
50553		A	Kidney endoscopy	5.98	3.83	4.53	2.22	2.63	0.47	000
50555		A	Kidney endoscopy & biopsy	6.52	4.03	4.89	2.46	2.90	0.46	000
50557		A	Kidney endoscopy & treatment	6.61	4.13	5.02	2.49	2.94	0.46	000
50561		A	Kidney endoscopy & treatment	7.58	4.62	5.61	2.81	3.33	0.54	000
50562		A	Renal scope w/tumor resect	10.90	NA	NA	4.34	5.19	0.76	090
50570		A	Kidney endoscopy	9.53	NA	NA	3.42	4.08	0.67	000
50572		A	Kidney endoscopy	10.33	NA	NA	3.68	4.41	0.72	000
50574		A	Kidney endoscopy & biopsy	11.00	NA	NA	3.90	4.65	0.77	000
50575		A	Kidney endoscopy	13.96	NA	NA	4.88	5.82	0.98	000
50576		A	Kidney endoscopy & treatment	10.97	NA	NA	3.89	4.65	0.77	000
50580		A	Kidney endoscopy & treatment	11.84	NA	NA	4.18	4.91	0.83	000
50590		A	Fragmenting of kidney stone	9.77	13.09	15.51	4.91	5.71	0.68	090
50592		A	Perc rf ablate renal tumor	6.80	64.70	86.46	2.58	3.13	0.47	010
50593		A	Perc cryo ablate renal tum	9.13	98.27	115.07	3.49	3.63	0.62	010
50600		A	Exploration of ureter	17.17	NA	NA	7.36	8.47	1.19	090
50605		A	Insert ureteral support	16.79	NA	NA	7.84	7.97	1.92	090
50610		A	Removal of ureter stone	17.25	NA	NA	7.44	8.69	1.20	090
50620		A	Removal of ureter stone	16.43	NA	NA	7.17	8.37	1.14	090

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50630		A	Removal of ureter stone	16.21	NA	NA	7.10	8.02	1.13	090
50650		A	Removal of ureter	18.82	NA	NA	8.21	9.48	1.35	090
50660		A	Removal of ureter	21.02	NA	NA	8.87	10.25	1.47	090
50684		A	Injection for ureter x-ray	0.76	3.32	4.04	0.52	0.60	0.05	000
50686		A	Measure ureter pressure	1.51	2.29	1.33	0.88	0.97	0.15	000
50688		A	Change of ureter tube/stent	1.20	NA	NA	0.83	0.98	0.08	010
50690		A	Injection for ureter x-ray	1.16	1.24	1.52	0.63	0.75	0.08	000
50700		A	Revision of ureter	16.69	NA	NA	7.67	8.63	1.16	090
50715		A	Release of ureter	20.64	NA	NA	9.68	9.28	2.17	090
50722		A	Release of ureter	17.95	NA	NA	8.76	8.15	2.19	090
50725		A	Release/revise ureter	20.20	NA	NA	8.60	9.55	1.41	090
50727		A	Revise ureter	8.28	NA	NA	4.73	5.43	0.60	090
50728		A	Revise ureter	12.18	NA	NA	5.97	6.68	0.84	090
50740		A	Fusion of ureter & kidney	20.07	NA	NA	10.27	9.46	3.08	090
50750		A	Fusion of ureter & kidney	21.22	NA	NA	8.94	10.55	1.49	090
50760		A	Fusion of ureters	20.07	NA	NA	8.96	9.65	1.93	090
50770		A	Splicing of ureters	21.22	NA	NA	8.94	9.70	1.49	090
50780		A	Reimplant ureter in bladder	19.95	NA	NA	8.78	9.79	1.68	090
50782		A	Reimplant ureter in bladder	19.66	NA	NA	8.43	9.44	3.02	090
50783		A	Reimplant ureter in bladder	20.70	NA	NA	10.50	9.85	1.45	090
50785		A	Reimplant ureter in bladder	22.23	NA	NA	9.40	10.81	1.63	090
50800		A	Implant ureter in bowel	16.41	NA	NA	7.59	8.70	1.25	090
50810		A	Fusion of ureter & bowel	22.61	NA	NA	12.04	10.77	3.46	090
50815		A	Urine shunt to intestine	22.26	NA	NA	9.66	11.19	1.56	090
50820		A	Construct bowel bladder	24.07	NA	NA	10.30	11.47	1.92	090
50825		A	Construct bowel bladder	30.68	NA	NA	12.55	14.47	2.29	090
50830		A	Revise urine flow	33.77	NA	NA	13.45	15.22	2.37	090
50840		A	Replace ureter by bowel	22.39	NA	NA	9.71	11.31	1.56	090
50845		A	Appendico-vesicostomy	22.46	NA	NA	10.11	11.73	1.57	090
50860		A	Transplant ureter to skin	17.08	NA	NA	7.58	8.73	1.19	090
50900		A	Repair of ureter	15.04	NA	NA	7.21	7.82	1.04	090
50920		A	Closure ureter/skin fistula	15.81	NA	NA	7.16	8.32	1.10	090
50930		A	Closure ureter/bowel fistula	20.19	NA	NA	8.60	9.17	3.10	090
50940		A	Release of ureter	15.93	NA	NA	7.20	8.22	1.11	090
50945		A	Laparoscopy ureterolithotomy	17.97	NA	NA	7.49	8.74	1.25	090
50947		A	Laparo new ureter/bladder	25.78	NA	NA	10.44	11.99	1.82	090
50948		A	Laparo new ureter/bladder	23.82	NA	NA	9.58	11.33	1.68	090
50949		C	Laparoscope proc, ureter	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50951		A	Endoscopy of ureter	5.83	3.79	4.63	2.25	2.66	0.41	000

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50953		A	Endoscopy of ureter	6.23	3.96	4.82	2.65	3.13	0.44	000
50955		A	Ureter endoscopy & biopsy	6.74	4.16	5.39	2.83	3.36	0.47	000
50957		A	Ureter endoscopy & treatment	6.78	4.23	5.11	2.56	3.01	0.47	000
50961		A	Ureter endoscopy & treatment	6.04	3.85	4.69	2.30	2.74	0.42	000
50970		A	Ureter endoscopy	7.13	NA	NA	2.63	3.13	0.50	000
50972		A	Ureter endoscopy & catheter	6.88	NA	NA	2.55	3.01	0.48	000
50974		A	Ureter endoscopy & biopsy	9.16	NA	NA	3.30	3.93	0.64	000
50976		A	Ureter endoscopy & treatment	9.03	NA	NA	3.25	3.85	0.63	000
50980		A	Ureter endoscopy & treatment	6.84	NA	NA	2.54	3.02	0.48	000
5100F		I	Rsk fx ref w/n 24 hrs x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
51020		A	Incise & treat bladder	7.69	NA	NA	4.42	5.10	0.56	090
51030		A	Incise & treat bladder	7.81	NA	NA	4.04	4.76	0.54	090
51040		A	Incise & drain bladder	4.49	NA	NA	2.95	3.46	0.32	090
51045		A	Incise bladder/drain ureter	7.81	NA	NA	4.66	5.01	0.75	090
51050		A	Removal of bladder stone	7.97	NA	NA	4.27	4.97	0.56	090
51060		A	Removal of ureter stone	9.95	NA	NA	5.12	5.98	0.69	090
51065		A	Remove ureter calculus	9.95	NA	NA	5.06	5.87	0.69	090
51080		A	Drainage of bladder abscess	6.71	NA	NA	3.84	4.40	0.46	090
51100		A	Drain bladder by needle	0.78	0.80	0.88	0.25	0.28	0.06	000
51101		A	Drain bladder by trocar/cath	1.02	2.10	2.37	0.36	0.38	0.10	000
51102		A	Drain bl w/cath insertion	2.70	2.98	3.59	1.10	1.33	0.21	000
51500		A	Removal of bladder cyst	11.05	NA	NA	5.48	5.88	0.76	090
51520		A	Removal of bladder lesion	10.21	NA	NA	5.21	5.85	0.71	090
51525		A	Removal of bladder lesion	15.42	NA	NA	7.00	8.09	1.12	090
51530		A	Removal of bladder lesion	13.71	NA	NA	6.58	7.25	1.19	090
51535		A	Repair of ureter lesion	13.90	NA	NA	6.40	7.23	0.96	090
51550		A	Partial removal of bladder	17.23	NA	NA	7.80	8.59	1.54	090
51555		A	Partial removal of bladder	23.18	NA	NA	9.88	11.09	1.88	090
51565		A	Revise bladder & ureter(s)	23.68	NA	NA	10.13	11.44	1.76	090
51570		A	Removal of bladder	27.46	NA	NA	11.24	12.68	2.03	090
51575		A	Removal of bladder & nodes	34.18	NA	NA	13.61	15.84	2.41	090
51580		A	Remove bladder/revise tract	35.37	NA	NA	14.27	16.77	2.48	090
51585		A	Removal of bladder & nodes	39.64	NA	NA	15.67	18.42	2.78	090
51590		A	Remove bladder/revise tract	36.33	NA	NA	14.29	16.58	2.65	090
51595		A	Remove bladder/revise tract	41.32	NA	NA	16.11	18.78	2.97	090
51596		A	Remove bladder/create pouch	44.26	NA	NA	17.43	20.38	3.13	090
51597		A	Removal of pelvic structures	42.86	NA	NA	17.16	19.54	3.28	090
51600		A	Injection for bladder x-ray	0.88	3.57	4.29	0.28	0.33	0.06	000
51605		A	Preparation for bladder xray	0.64	NA	NA	0.35	0.41	0.04	000

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51610		A	Injection for bladder x-ray	1.05	1.60	1.94	0.59	0.68	0.07	000
51700		A	Irrigation of bladder	0.88	1.19	1.46	0.30	0.34	0.07	000
51701		A	Insert bladder catheter	0.50	0.85	1.11	0.22	0.24	0.04	000
51702		A	Insert temp bladder cath	0.50	1.23	1.58	0.28	0.32	0.04	000
51703		A	Insert bladder cath, complex	1.47	1.78	2.28	0.66	0.76	0.11	000
51705		A	Change of bladder tube	1.05	1.58	2.00	0.69	0.79	0.07	010
51710		A	Change of bladder tube	1.52	2.11	2.74	0.94	1.09	0.11	010
51715		A	Endoscopic injection/implant	3.73	3.54	4.20	1.50	1.69	0.30	000
51720		A	Treatment of bladder lesion	1.50	1.27	1.60	0.61	0.74	0.11	000
51725		A	Simple cystometrogram	1.51	3.35	4.32	NA	NA	0.10	000
51725	TC	A	Simple cystometrogram	0.00	2.83	3.75	NA	NA	0.01	000
51725	26	A	Simple cystometrogram	1.51	0.52	0.57	0.52	0.57	0.09	000
51726		A	Complex cystometrogram	1.71	5.56	6.85	NA	NA	0.15	000
51726	TC	A	Complex cystometrogram	0.00	4.97	6.20	NA	NA	0.05	000
51726	26	A	Complex cystometrogram	1.71	0.59	0.65	0.59	0.65	0.10	000
51727		A	Cystometrogram w/up	2.11	5.81	5.81	NA	NA	0.15	000
51727	TC	A	Cystometrogram w/up	0.00	5.06	5.06	NA	NA	0.01	000
51727	26	A	Cystometrogram w/up	2.11	0.75	0.75	0.75	0.75	0.14	000
51728		A	Cystometrogram w/vp	2.11	5.82	5.82	NA	NA	0.13	000
51728	TC	A	Cystometrogram w/vp	0.00	5.09	5.09	NA	NA	0.01	000
51728	26	A	Cystometrogram w/vp	2.11	0.73	0.73	0.73	0.73	0.12	000
51729		A	Cystometrogram w/vp&up	2.11	5.89	5.89	NA	NA	0.14	000
51729	TC	A	Cystometrogram w/vp&up	0.00	5.15	5.15	NA	NA	0.01	000
51729	26	A	Cystometrogram w/vp&up	2.11	0.74	0.74	0.74	0.74	0.13	000
51736		A	Urine flow measurement	0.61	0.73	0.84	NA	NA	0.04	000
51736	TC	A	Urine flow measurement	0.00	0.52	0.60	NA	NA	0.01	000
51736	26	A	Urine flow measurement	0.61	0.21	0.24	0.21	0.24	0.03	000
51741		A	Electro-uroflowmetry, first	1.14	0.99	1.14	NA	NA	0.06	000
51741	TC	A	Electro-uroflowmetry, first	0.00	0.61	0.70	NA	NA	0.01	000
51741	26	A	Electro-uroflowmetry, first	1.14	0.38	0.44	0.38	0.44	0.05	000
51784		A	Anal/urinary muscle study	1.53	3.31	3.90	NA	NA	0.10	000
51784	TC	A	Anal/urinary muscle study	0.00	2.78	3.33	NA	NA	0.01	000
51784	26	A	Anal/urinary muscle study	1.53	0.53	0.57	0.53	0.57	0.09	000
51785		A	Anal/urinary muscle study	1.53	3.78	4.39	NA	NA	0.10	000
51785	TC	A	Anal/urinary muscle study	0.00	3.25	3.81	NA	NA	0.01	000
51785	26	A	Anal/urinary muscle study	1.53	0.53	0.58	0.53	0.58	0.09	000
51792		A	Urinary reflex study	1.10	4.03	4.99	NA	NA	0.08	000
51792	TC	A	Urinary reflex study	0.00	3.65	4.57	NA	NA	0.01	000
51792	26	A	Urinary reflex study	1.10	0.38	0.42	0.38	0.42	0.07	000

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51797		A	Intraabdominal pressure test	0.80	1.94	2.98	NA	NA	0.05	ZZZ
51797	TC	A	Intraabdominal pressure test	0.00	1.67	2.63	NA	NA	0.01	ZZZ
51797	26	A	Intraabdominal pressure test	0.80	0.27	0.35	0.27	0.35	0.04	ZZZ
51798		A	Us urine capacity measure	0.00	0.44	0.51	NA	NA	0.01	XXX
51800		A	Revision of bladder/urethra	18.89	NA	NA	8.35	9.61	1.40	090
51820		A	Revision of urinary tract	19.59	NA	NA	8.68	9.38	1.36	090
51840		A	Attach bladder/urethra	11.36	NA	NA	5.75	5.98	1.07	090
51841		A	Attach bladder/urethra	13.68	NA	NA	6.61	6.89	1.32	090
51845		A	Repair bladder neck	10.15	NA	NA	5.10	5.67	0.86	090
51860		A	Repair of bladder wound	12.60	NA	NA	6.49	6.76	1.33	090
51865		A	Repair of bladder wound	15.80	NA	NA	7.39	8.15	1.39	090
51880		A	Repair of bladder opening	7.87	NA	NA	4.22	4.63	0.70	090
51900		A	Repair bladder/vagina lesion	14.63	NA	NA	7.11	7.64	1.01	090
51920		A	Close bladder-uterus fistula	13.41	NA	NA	6.44	7.10	0.93	090
51925		A	Hysterectomy/bladder repair	17.53	NA	NA	9.00	9.10	2.13	090
51940		A	Correction of bladder defect	30.66	NA	NA	12.33	13.33	2.15	090
51960		A	Revision of bladder & bowel	25.40	NA	NA	10.85	12.55	1.92	090
51980		A	Construct bladder opening	12.57	NA	NA	5.98	6.89	0.87	090
51990		A	Laparo urethral suspension	13.36	NA	NA	6.42	6.52	1.26	090
51992		A	Laparo sling operation	14.87	NA	NA	7.06	6.94	1.61	090
51999		C	Laparoscope proc, bla	0.00	0.00	0.00	0.00	0.00	0.00	YYY
52000		A	Cystoscopy	2.23	2.81	3.45	1.05	1.21	0.16	000
52001		A	Cystoscopy, removal of clots	5.44	3.99	4.96	2.12	2.47	0.38	000
52005		A	Cystoscopy & ureter catheter	2.37	4.35	5.44	1.10	1.28	0.17	000
52007		A	Cystoscopy and biopsy	3.02	8.15	11.31	1.31	1.54	0.21	000
5200F		I	Eval appros surg thxpy epi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
52010		A	Cystoscopy & duct catheter	3.02	6.15	7.83	1.31	1.43	0.21	000
52204		A	Cystoscopy w/biopsy(s)	2.59	6.29	9.09	1.11	1.29	0.18	000
52214		A	Cystoscopy and treatment	3.70	11.86	12.61	1.48	2.17	0.26	000
52224		A	Cystoscopy and treatment	3.14	11.26	18.28	1.29	1.53	0.22	000
52234		A	Cystoscopy and treatment	4.62	NA	NA	1.84	2.17	0.33	000
52235		A	Cystoscopy and treatment	5.44	NA	NA	2.13	2.53	0.38	000
52240		A	Cystoscopy and treatment	9.71	NA	NA	3.54	4.21	0.69	000
52250		A	Cystoscopy and radiotracer	4.49	NA	NA	1.88	2.19	0.33	000
52260		A	Cystoscopy and treatment	3.91	NA	NA	1.60	1.86	0.29	000
52265		A	Cystoscopy and treatment	2.94	6.00	8.30	1.33	1.43	0.25	000
52270		A	Cystoscopy & revise urethra	3.36	5.34	7.48	1.40	1.65	0.24	000
52275		A	Cystoscopy & revise urethra	4.69	7.08	10.10	1.84	2.18	0.33	000
52276		A	Cystoscopy and treatment	4.99	NA	NA	1.98	2.34	0.35	000

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52277		A	Cystoscopy and treatment	6.16	NA	NA	2.68	2.87	0.43	000
52281		A	Cystoscopy and treatment	2.80	4.03	5.41	1.24	1.45	0.20	000
52282		A	Cystoscopy, implant stent	6.39	NA	NA	2.46	2.86	0.48	000
52283		A	Cystoscopy and treatment	3.73	3.24	3.95	1.56	1.80	0.27	000
52285		A	Cystoscopy and treatment	3.60	3.39	4.13	1.52	1.75	0.27	000
52290		A	Cystoscopy and treatment	4.58	NA	NA	1.83	2.17	0.33	000
52300		A	Cystoscopy and treatment	5.30	NA	NA	2.15	2.46	0.41	000
52301		A	Cystoscopy and treatment	5.50	NA	NA	2.18	2.59	0.39	000
52305		A	Cystoscopy and treatment	5.30	NA	NA	2.03	2.39	0.37	000
52310		A	Cystoscopy and treatment	2.81	3.09	3.99	1.16	1.36	0.20	000
52315		A	Cystoscopy and treatment	5.20	5.11	6.80	2.00	2.38	0.37	000
52317		A	Remove bladder stone	6.71	12.93	18.55	2.44	2.90	0.47	000
52318		A	Remove bladder stone	9.18	NA	NA	3.29	3.92	0.65	000
52320		A	Cystoscopy and treatment	4.69	NA	NA	1.79	2.12	0.34	000
52325		A	Cystoscopy, stone removal	6.15	NA	NA	2.28	2.70	0.43	000
52327		A	Cystoscopy, inject material	5.18	NA	NA	1.72	2.05	0.38	000
52330		A	Cystoscopy and treatment	5.03	7.12	14.57	1.91	2.25	0.36	000
52332		A	Cystoscopy and treatment	2.83	9.36	10.50	1.25	1.46	0.20	000
52334		A	Create passage to kidney	4.82	NA	NA	1.90	2.25	0.34	000
52341		A	Cysto w/ureter stricture tx	5.35	NA	NA	2.22	2.66	0.38	000
52342		A	Cysto w/up stricture tx	5.85	NA	NA	2.38	2.86	0.41	000
52343		A	Cysto w/renal stricture tx	6.55	NA	NA	2.61	3.14	0.46	000
52344		A	Cysto/uretero, stricture tx	7.05	NA	NA	2.90	3.47	0.50	000
52345		A	Cysto/uretero w/up stricture	7.55	NA	NA	3.07	3.67	0.53	000
52346		A	Cystouretero w/renal strict	8.58	NA	NA	3.40	4.08	0.60	000
52351		A	Cystouretero & or pyeloscope	5.85	NA	NA	2.38	2.82	0.41	000
52352		A	Cystouretero w/stone remove	6.87	NA	NA	2.80	3.30	0.48	000
52353		A	Cystouretero w/lithotripsy	7.96	NA	NA	3.15	3.74	0.56	000
52354		A	Cystouretero w/biopsy	7.33	NA	NA	2.95	3.49	0.52	000
52355		A	Cystouretero w/excise tumor	8.81	NA	NA	3.43	4.08	0.62	000
52400		A	Cystouretero w/congen repr	8.69	NA	NA	2.81	4.29	0.61	090
52402		A	Cystourethro cut ejacul duct	5.27	NA	NA	1.77	2.12	0.37	000
52450		A	Incision of prostate	7.78	NA	NA	4.37	5.07	0.54	090
52500		A	Revision of bladder neck	8.14	NA	NA	4.49	5.24	0.56	090
52601		A	Prostatectomy (TURP)	15.26	NA	NA	6.80	7.55	1.07	090
52630		A	Remove prostate regrowth	7.73	NA	NA	3.84	4.42	0.54	090
52640		A	Relieve bladder contracture	4.79	NA	NA	2.81	3.39	0.33	090
52647		A	Laser surgery of prostate	11.30	31.63	45.95	5.53	6.41	0.78	090
52648		A	Laser surgery of prostate	12.15	32.13	46.39	5.81	6.74	0.85	090

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52649		A	Prostate laser enucleation	17.29	NA	NA	7.52	9.44	1.20	090
52700		A	Drainage of prostate abscess	7.49	NA	NA	3.94	4.44	0.52	090
53000		A	Incision of urethra	2.33	NA	NA	1.50	1.74	0.17	010
53010		A	Incision of urethra	4.45	NA	NA	3.10	3.61	0.31	090
53020		A	Incision of urethra	1.77	NA	NA	0.77	0.90	0.13	000
53025		A	Incision of urethra	1.13	NA	NA	0.70	0.67	0.06	000
53040		A	Drainage of urethra abscess	6.55	NA	NA	3.61	4.16	0.45	090
53060		A	Drainage of urethra abscess	2.68	2.01	2.06	1.58	1.52	0.32	010
53080		A	Drainage of urinary leakage	6.92	NA	NA	3.94	4.88	0.48	090
53085		A	Drainage of urinary leakage	11.18	NA	NA	5.42	5.70	1.03	090
53200		A	Biopsy of urethra	2.59	1.42	1.63	1.11	1.25	0.19	000
53210		A	Removal of urethra	13.72	NA	NA	6.43	7.38	0.95	090
53215		A	Removal of urethra	16.85	NA	NA	7.39	8.68	1.18	090
53220		A	Treatment of urethra lesion	7.63	NA	NA	4.15	4.74	0.53	090
53230		A	Removal of urethra lesion	10.44	NA	NA	5.31	6.01	0.83	090
53235		A	Removal of urethra lesion	10.99	NA	NA	5.44	6.45	0.76	090
53240		A	Surgery for urethra pouch	7.08	NA	NA	3.90	4.62	0.49	090
53250		A	Removal of urethra gland	6.52	NA	NA	3.50	4.30	1.01	090
53260		A	Treatment of urethra lesion	3.03	2.12	2.38	1.64	1.77	0.26	010
53265		A	Treatment of urethra lesion	3.17	2.37	2.82	1.65	1.86	0.25	010
53270		A	Removal of urethra gland	3.14	2.23	2.38	1.76	1.80	0.38	010
53275		A	Repair of urethra defect	4.57	NA	NA	2.24	2.66	0.33	010
53400		A	Revise urethra, stage 1	14.13	NA	NA	6.75	7.78	1.01	090
53405		A	Revise urethra, stage 2	15.66	NA	NA	7.11	8.39	1.09	090
53410		A	Reconstruction of urethra	17.68	NA	NA	7.88	9.21	1.24	090
53415		A	Reconstruction of urethra	20.70	NA	NA	8.89	10.30	1.49	090
53420		A	Reconstruct urethra, stage 1	15.17	NA	NA	6.77	7.10	1.05	090
53425		A	Reconstruct urethra, stage 2	17.07	NA	NA	7.39	8.77	1.19	090
53430		A	Reconstruction of urethra	17.43	NA	NA	7.78	8.53	1.43	090
53431		A	Reconstruct urethra/bladder	21.18	NA	NA	8.99	10.47	1.48	090
53440		A	Male sling procedure	15.54	NA	NA	7.49	8.61	1.08	090
53442		A	Remove/revise male sling	13.49	NA	NA	6.84	7.82	0.94	090
53444		A	Insert tandem cuff	14.19	NA	NA	6.51	7.63	0.98	090
53445		A	Insert uro/ves nck sphincter	15.39	NA	NA	7.43	8.76	1.07	090
53446		A	Remove uro sphincter	11.02	NA	NA	5.66	6.64	0.78	090
53447		A	Remove/replace ur sphincter	14.28	NA	NA	6.79	7.99	1.01	090
53448		A	Remov/replc ur sphinctr comp	23.44	NA	NA	10.01	11.76	1.64	090
53449		A	Repair uro sphincter	10.56	NA	NA	5.33	6.24	0.74	090
53450		A	Revision of urethra	6.77	NA	NA	3.81	4.44	0.47	090

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53460		A	Revision of urethra	7.75	NA	NA	4.11	4.81	0.54	090
53500		A	Urethrlys, transvag w/ scope	13.00	NA	NA	6.44	7.20	1.06	090
53502		A	Repair of urethra injury	8.26	NA	NA	4.35	4.99	0.57	090
53505		A	Repair of urethra injury	8.26	NA	NA	4.34	5.08	0.57	090
53510		A	Repair of urethra injury	10.96	NA	NA	5.44	6.37	0.76	090
53515		A	Repair of urethra injury	14.22	NA	NA	6.51	7.55	0.99	090
53520		A	Repair of urethra defect	9.48	NA	NA	4.95	5.77	0.65	090
53600		A	Dilate urethra stricture	1.21	0.91	1.12	0.47	0.55	0.09	000
53601		A	Dilate urethra stricture	0.98	1.05	1.30	0.42	0.50	0.07	000
53605		A	Dilate urethra stricture	1.28	NA	NA	0.42	0.50	0.09	000
53620		A	Dilate urethra stricture	1.62	1.32	1.71	0.67	0.79	0.11	000
53621		A	Dilate urethra stricture	1.35	1.39	1.80	0.54	0.64	0.09	000
53660		A	Dilation of urethra	0.71	1.03	1.27	0.37	0.42	0.05	000
53661		A	Dilation of urethra	0.72	1.00	1.24	0.34	0.39	0.05	000
53665		A	Dilation of urethra	0.76	NA	NA	0.26	0.28	0.07	000
53850		A	Prostatic microwave thermotx	10.08	37.08	55.23	4.72	5.49	0.70	090
53852		A	Prostatic rf thermotx	10.83	34.95	52.10	5.34	6.19	0.75	090
53855		A	Insert prost urethral stent	1.64	16.31	16.31	0.54	0.54	0.11	000
53899		C	Urology surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54000		A	Slitting of prepuce	1.59	2.08	2.65	1.17	1.35	0.11	010
54001		A	Slitting of prepuce	2.24	2.39	2.98	1.34	1.54	0.16	010
54015		A	Drain penis lesion	5.36	NA	NA	2.69	3.10	0.40	010
54050		A	Destruction, penis lesion(s)	1.29	2.01	2.04	1.39	1.37	0.12	010
54055		A	Destruction, penis lesion(s)	1.25	1.71	1.88	1.11	1.16	0.10	010
54056		A	Cryosurgery, penis lesion(s)	1.29	2.25	2.23	1.54	1.48	0.13	010
54057		A	Laser surg, penis lesion(s)	1.29	2.11	2.44	1.13	1.23	0.10	010
54060		A	Excision of penis lesion(s)	1.98	2.51	3.02	1.38	1.52	0.15	010
54065		A	Destruction, penis lesion(s)	2.47	3.06	3.16	1.98	1.90	0.22	010
54100		A	Biopsy of penis	1.90	2.99	3.22	1.37	1.32	0.17	000
54105		A	Biopsy of penis	3.54	3.14	3.94	1.97	2.33	0.25	010
54110		A	Treatment of penis lesion	10.92	NA	NA	5.31	6.18	0.76	090
54111		A	Treat penis lesion, graft	14.42	NA	NA	6.46	7.60	1.00	090
54112		A	Treat penis lesion, graft	16.98	NA	NA	7.49	8.86	1.18	090
54115		A	Treatment of penis lesion	6.95	4.62	5.43	4.00	4.63	0.48	090
54120		A	Partial removal of penis	11.01	NA	NA	5.42	6.31	0.78	090
54125		A	Removal of penis	14.56	NA	NA	6.64	7.70	1.06	090
54130		A	Remove penis & nodes	21.84	NA	NA	9.34	10.97	1.53	090
54135		A	Remove penis & nodes	28.17	NA	NA	11.41	13.46	1.98	090
54150		A	Circumcision w/regionl block	1.90	2.02	2.59	0.68	0.74	0.16	000

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54160		A	Circumcision, neonate	2.53	2.96	3.76	1.22	1.43	0.18	010
54161		A	Circum 28 days or older	3.32	NA	NA	1.78	2.07	0.24	010
54162		A	Lysis penil circumic lesion	3.32	3.16	4.01	1.84	2.08	0.24	010
54163		A	Repair of circumcision	3.32	NA	NA	2.28	2.65	0.23	010
54164		A	Frenulotomy of penis	2.82	NA	NA	2.12	2.45	0.20	010
54200		A	Treatment of penis lesion	1.11	1.57	1.90	1.03	1.21	0.08	010
54205		A	Treatment of penis lesion	8.97	NA	NA	4.82	5.74	0.62	090
54220		A	Treatment of penis lesion	2.42	2.60	3.31	1.10	1.26	0.18	000
54230		A	Prepare penis study	1.34	1.11	1.32	0.73	0.85	0.09	000
54231		A	Dynamic cavernosometry	2.04	1.53	1.80	0.99	1.17	0.14	000
54235		A	Penile injection	1.19	1.11	1.28	0.72	0.82	0.08	000
54240		A	Penis study	1.31	1.22	1.42	NA	NA	0.07	000
54240	TC	A	Penis study	0.00	0.79	0.91	NA	NA	0.01	000
54240	26	A	Penis study	1.31	0.43	0.51	0.43	0.51	0.06	000
54250		A	Penis study	2.22	1.02	1.19	NA	NA	0.11	000
54250	TC	A	Penis study	0.00	0.28	0.32	NA	NA	0.01	000
54250	26	A	Penis study	2.22	0.74	0.87	0.74	0.87	0.10	000
54300		A	Revision of penis	11.20	NA	NA	5.50	6.56	0.78	090
54304		A	Revision of penis	13.28	NA	NA	6.25	7.50	0.92	090
54308		A	Reconstruction of urethra	12.62	NA	NA	5.99	7.17	0.87	090
54312		A	Reconstruction of urethra	14.51	NA	NA	6.80	8.18	1.01	090
54316		A	Reconstruction of urethra	18.05	NA	NA	7.99	9.57	1.25	090
54318		A	Reconstruction of urethra	12.43	NA	NA	6.67	7.35	0.62	090
54322		A	Reconstruction of urethra	13.98	NA	NA	6.37	7.65	0.97	090
54324		A	Reconstruction of urethra	17.55	NA	NA	7.74	9.32	1.22	090
54326		A	Reconstruction of urethra	17.02	NA	NA	7.65	8.43	1.18	090
54328		A	Revise penis/urethra	16.89	NA	NA	7.61	8.87	1.17	090
54332		A	Revise penis/urethra	18.37	NA	NA	8.10	9.64	1.28	090
54336		A	Revise penis/urethra	21.62	NA	NA	9.44	9.97	1.51	090
54340		A	Secondary urethral surgery	9.71	NA	NA	5.07	5.81	0.67	090
54344		A	Secondary urethral surgery	17.06	NA	NA	7.66	9.20	1.18	090
54348		A	Secondary urethral surgery	18.32	NA	NA	8.98	10.01	0.91	090
54352		A	Reconstruct urethra/penis	26.13	NA	NA	10.92	13.15	1.84	090
54360		A	Penis plastic surgery	12.78	NA	NA	6.00	7.18	0.89	090
54380		A	Repair penis	14.18	NA	NA	6.63	7.94	0.98	090
54385		A	Repair penis	16.56	NA	NA	10.09	10.71	1.75	090
54390		A	Repair penis and bladder	22.77	NA	NA	9.66	9.98	1.59	090
54400		A	Insert semi-rigid prosthesis	9.17	NA	NA	4.59	5.43	0.64	090
54401		A	Insert self-contd prosthesis	10.44	NA	NA	6.44	7.55	0.73	090

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54405		A	Insert multi-comp penis pros	14.52	NA	NA	6.59	7.72	1.01	090
54406		A	Remove muti-comp penis pros	12.89	NA	NA	6.12	7.17	0.90	090
54408		A	Repair multi-comp penis pros	13.91	NA	NA	6.68	7.76	0.98	090
54410		A	Remove/replace penis prosth	15.18	NA	NA	7.22	8.49	1.06	090
54411		A	Remov/replc penis pros, comp	18.35	NA	NA	8.46	9.80	1.27	090
54415		A	Remove self-contd penis pros	8.88	NA	NA	4.81	5.60	0.62	090
54416		A	Remv/repl penis contain pros	12.08	NA	NA	6.34	7.37	0.83	090
54417		A	Remv/replc penis pros, compl	16.10	NA	NA	7.33	8.55	1.12	090
54420		A	Revision of penis	12.39	NA	NA	5.94	7.05	0.86	090
54430		A	Revision of penis	11.06	NA	NA	5.56	6.58	0.77	090
54435		A	Revision of penis	6.81	NA	NA	3.95	4.65	0.47	090
54440		C	Repair of penis	0.00	0.00	0.00	0.00	0.00	0.00	090
54450		A	Preputial stretching	1.12	0.68	0.86	0.40	0.48	0.08	000
54500		A	Biopsy of testis	1.31	NA	NA	0.63	0.75	0.09	000
54505		A	Biopsy of testis	3.50	NA	NA	1.93	2.31	0.24	010
54512		A	Excise lesion testis	9.33	NA	NA	4.66	5.34	0.67	090
54520		A	Removal of testis	5.30	NA	NA	3.10	3.52	0.44	090
54522		A	Orchiectomy, partial	10.25	NA	NA	5.08	5.62	0.71	090
54530		A	Removal of testis	8.46	NA	NA	4.63	5.39	0.62	090
54535		A	Extensive testis surgery	13.19	NA	NA	6.18	6.96	0.91	090
54550		A	Exploration for testis	8.41	NA	NA	4.35	4.99	0.58	090
54560		A	Exploration for testis	12.10	NA	NA	5.77	6.21	0.84	090
54600		A	Reduce testis torsion	7.64	NA	NA	4.10	4.76	0.53	090
54620		A	Suspension of testis	5.21	NA	NA	2.58	3.07	0.36	010
54640		A	Suspension of testis	7.73	NA	NA	4.57	5.07	0.62	090
54650		A	Orchiopexy (Fowler-Stephens)	12.39	NA	NA	6.10	6.93	0.86	090
54660		A	Revision of testis	5.74	NA	NA	3.47	3.99	0.40	090
54670		A	Repair testis injury	6.65	NA	NA	3.82	4.42	0.46	090
54680		A	Relocation of testis(es)	14.04	NA	NA	6.47	7.33	0.97	090
54690		A	Laparoscopy, orchiectomy	11.70	NA	NA	6.62	5.94	1.80	090
54692		A	Laparoscopy, orchiopexy	13.74	NA	NA	6.07	7.16	0.96	090
54699		C	Laparoscope proc, testis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54700		A	Drainage of scrotum	3.47	NA	NA	2.05	2.29	0.29	010
54800		A	Biopsy of epididymis	2.33	NA	NA	1.66	1.39	0.24	000
54830		A	Remove epididymis lesion	6.01	NA	NA	3.62	4.12	0.45	090
54840		A	Remove epididymis lesion	5.27	NA	NA	3.02	3.55	0.37	090
54860		A	Removal of epididymis	6.95	NA	NA	3.88	4.51	0.49	090
54861		A	Removal of epididymis	9.70	NA	NA	4.98	5.78	0.67	090
54865		A	Explore epididymis	5.77	NA	NA	3.48	4.00	0.40	090

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54900		A	Fusion of spermatic ducts	14.20	NA	NA	7.32	6.92	0.70	090
54901		A	Fusion of spermatic ducts	19.10	NA	NA	9.33	10.18	0.95	090
55000		A	Drainage of hydrocele	1.43	1.52	1.85	0.78	0.87	0.11	000
55040		A	Removal of hydrocele	5.45	NA	NA	3.27	3.73	0.44	090
55041		A	Removal of hydroceles	8.54	NA	NA	4.66	5.33	0.64	090
55060		A	Repair of hydrocele	6.15	NA	NA	3.67	4.17	0.48	090
55100		A	Drainage of scrotum abscess	2.45	2.92	3.44	1.80	1.98	0.21	010
55110		A	Explore scrotum	6.33	NA	NA	3.67	4.18	0.48	090
55120		A	Removal of scrotum lesion	5.72	NA	NA	3.50	3.95	0.43	090
55150		A	Removal of scrotum	8.14	NA	NA	4.54	5.17	0.61	090
55175		A	Revision of scrotum	5.87	NA	NA	3.50	4.04	0.42	090
55180		A	Revision of scrotum	11.78	NA	NA	6.07	6.92	0.92	090
55200		A	Incision of sperm duct	4.55	6.24	8.51	2.64	3.00	0.32	090
55250		A	Removal of sperm duct(s)	3.37	6.04	8.17	2.44	2.82	0.23	090
55300		A	Prepare, sperm duct x-ray	3.50	NA	NA	1.41	1.46	0.25	000
55400		A	Repair of sperm duct	8.61	NA	NA	4.33	5.14	0.60	090
55450		A	Ligation of sperm duct	4.43	4.57	5.87	2.25	2.56	0.31	010
55500		A	Removal of hydrocele	6.22	NA	NA	3.89	4.05	0.64	090
55520		A	Removal of sperm cord lesion	6.66	NA	NA	4.60	4.02	0.96	090
55530		A	Revise spermatic cord veins	5.75	NA	NA	3.35	3.86	0.44	090
55535		A	Revise spermatic cord veins	7.19	NA	NA	3.95	4.52	0.50	090
55540		A	Revise hernia & sperm veins	8.30	NA	NA	5.13	4.55	1.17	090
55550		A	Laparo ligate spermatic vein	7.20	NA	NA	3.90	4.35	0.50	090
55559		C	Laparo proc, spermatic cord	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55600		A	Incise sperm duct pouch	7.01	NA	NA	3.89	4.55	0.48	090
55605		A	Incise sperm duct pouch	8.76	NA	NA	4.73	5.09	0.60	090
55650		A	Remove sperm duct pouch	12.65	NA	NA	6.07	6.89	0.88	090
55680		A	Remove sperm pouch lesion	5.67	NA	NA	3.27	3.61	0.39	090
55700		A	Biopsy of prostate	2.58	2.86	3.67	1.07	1.20	0.18	000
55705		A	Biopsy of prostate	4.61	NA	NA	2.30	2.74	0.33	010
55706		A	Prostate saturation sampling	6.28	NA	NA	3.42	4.22	0.31	010
55720		A	Drainage of prostate abscess	7.73	NA	NA	4.00	4.64	0.54	090
55725		A	Drainage of prostate abscess	10.05	NA	NA	5.33	6.08	0.69	090
55801		A	Removal of prostate	19.80	NA	NA	8.74	10.04	1.37	090
55810		A	Extensive prostate surgery	24.29	NA	NA	10.18	11.74	1.81	090
55812		A	Extensive prostate surgery	29.89	NA	NA	12.23	14.30	2.10	090
55815		A	Extensive prostate surgery	32.95	NA	NA	13.24	15.53	2.31	090
55821		A	Removal of prostate	15.76	NA	NA	7.06	8.24	1.11	090
55831		A	Removal of prostate	17.19	NA	NA	7.54	8.80	1.20	090

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55840		A	Extensive prostate surgery	24.63	NA	NA	10.38	12.13	1.75	090
55842		A	Extensive prostate surgery	26.49	NA	NA	10.98	12.88	1.88	090
55845		A	Extensive prostate surgery	30.67	NA	NA	12.23	14.29	2.19	090
55860		A	Surgical exposure, prostate	15.84	NA	NA	6.97	8.21	1.09	090
55862		A	Extensive prostate surgery	20.04	NA	NA	8.62	10.19	1.40	090
55865		A	Extensive prostate surgery	24.57	NA	NA	10.32	12.18	1.73	090
55866		A	Laparo radical prostatectomy	32.46	NA	NA	13.19	15.37	2.30	090
55870		A	Electroejaculation	2.58	1.89	2.22	1.14	1.36	0.18	000
55873		A	Cryoablate prostate	13.60	147.06	45.92	6.30	10.14	1.46	090
55875		A	Transperi needle place, pros	13.46	NA	NA	6.46	7.47	0.93	090
55876		A	Place rt device/marker, pros	1.73	1.71	2.03	0.90	1.07	0.12	000
55899		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55920		A	Place needles pelvic for rt	8.31	NA	NA	3.70	3.55	0.58	000
55970		N	Sex transformation, M to F	0.00	0.00	0.00	0.00	0.00	0.00	XXX
55980		N	Sex transformation, F to M	0.00	0.00	0.00	0.00	0.00	0.00	XXX
56405		A	I & D of vulva/perineum	1.49	1.27	1.25	1.25	1.20	0.18	010
56420		A	Drainage of gland abscess	1.44	1.60	1.71	0.90	0.88	0.17	010
56440		A	Surgery for vulva lesion	2.89	NA	NA	1.79	1.70	0.35	010
56441		A	Lysis of labial lesion(s)	2.02	1.61	1.74	1.49	1.55	0.20	010
56442		A	Hymenotomy	0.68	NA	NA	0.53	0.54	0.08	000
56501		A	Destroy, vulva lesions, sim	1.58	1.68	1.71	1.31	1.28	0.19	010
56515		A	Destroy vulva lesion/s compl	3.08	2.56	2.53	1.99	1.88	0.36	010
56605		A	Biopsy of vulva/perineum	1.10	0.97	0.99	0.46	0.41	0.13	000
56606		A	Biopsy of vulva/perineum	0.55	0.40	0.41	0.21	0.19	0.07	ZZZ
56620		A	Partial removal of vulva	7.53	NA	NA	5.23	4.94	0.89	090
56625		A	Complete removal of vulva	9.68	NA	NA	5.73	5.29	1.16	090
56630		A	Extensive vulva surgery	14.80	NA	NA	7.84	7.05	1.84	090
56631		A	Extensive vulva surgery	18.99	NA	NA	9.84	8.80	2.31	090
56632		A	Extensive vulva surgery	21.86	NA	NA	11.69	10.34	2.65	090
56633		A	Extensive vulva surgery	19.62	NA	NA	9.98	8.87	2.39	090
56634		A	Extensive vulva surgery	20.66	NA	NA	10.58	9.41	2.51	090
56637		A	Extensive vulva surgery	24.75	NA	NA	11.89	10.66	3.01	090
56640		A	Extensive vulva surgery	24.78	NA	NA	11.83	10.36	3.02	090
56700		A	Partial removal of hymen	2.84	NA	NA	1.92	1.85	0.34	010
56740		A	Remove vagina gland lesion	4.88	NA	NA	2.73	2.55	0.60	010
56800		A	Repair of vagina	3.93	NA	NA	2.22	2.16	0.46	010
56805		A	Repair clitoris	19.88	NA	NA	9.57	8.83	2.42	090
56810		A	Repair of perineum	4.29	NA	NA	2.36	2.25	0.50	010
56820		A	Exam of vulva w/scope	1.50	1.27	1.27	0.68	0.62	0.18	000

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56821		A	Exam/biopsy of vulva w/scope	2.05	1.63	1.64	0.90	0.81	0.25	000
57000		A	Exploration of vagina	3.02	NA	NA	1.81	1.77	0.36	010
57010		A	Drainage of pelvic abscess	6.84	NA	NA	4.23	4.00	0.82	090
57020		A	Drainage of pelvic fluid	1.50	0.88	0.85	0.60	0.53	0.18	000
57022		A	I & d vaginal hematoma, pp	2.73	NA	NA	1.57	1.47	0.33	010
57023		A	I & d vag hematoma, non-ob	5.18	NA	NA	2.78	2.62	0.62	010
57061		A	Destroy vag lesions, simple	1.30	1.53	1.57	1.17	1.15	0.15	010
57065		A	Destroy vag lesions, complex	2.66	2.16	2.16	1.69	1.62	0.32	010
57100		A	Biopsy of vagina	1.20	1.01	1.01	0.50	0.44	0.14	000
57105		A	Biopsy of vagina	1.74	1.63	1.67	1.40	1.40	0.20	010
57106		A	Remove vagina wall, partial	7.50	NA	NA	4.82	4.54	0.85	090
57107		A	Remove vagina tissue, part	24.56	NA	NA	11.55	10.41	2.99	090
57109		A	Vaginectomy partial w/nodes	28.40	NA	NA	13.48	11.66	3.46	090
57110		A	Remove vagina wall, complete	15.48	NA	NA	7.57	7.01	1.86	090
57111		A	Remove vagina tissue, compl	28.40	NA	NA	13.48	12.02	3.46	090
57112		A	Vaginectomy w/nodes, compl	30.52	NA	NA	14.33	12.62	1.76	090
57120		A	Closure of vagina	8.28	NA	NA	4.77	4.57	0.97	090
57130		A	Remove vagina lesion	2.46	2.01	2.06	1.59	1.56	0.30	010
57135		A	Remove vagina lesion	2.70	2.12	2.15	1.69	1.64	0.32	010
57150		A	Treat vagina infection	0.55	0.58	0.70	0.21	0.19	0.07	000
57155		A	Insert uteri tandems/ovoids	6.87	NA	NA	4.09	3.97	0.42	090
57160		A	Insert pessary/other device	0.89	1.02	1.05	0.34	0.31	0.10	000
57170		A	Fitting of diaphragm/cap	0.91	0.63	0.78	0.35	0.30	0.11	000
57180		A	Treat vaginal bleeding	1.63	1.87	1.96	1.06	1.05	0.19	010
57200		A	Repair of vagina	4.42	NA	NA	3.14	3.07	0.51	090
57210		A	Repair vagina/perineum	5.71	NA	NA	3.62	3.52	0.66	090
57220		A	Revision of urethra	4.85	NA	NA	3.29	3.21	0.57	090
57230		A	Repair of urethral lesion	6.30	NA	NA	3.79	3.78	0.76	090
57240		A	Repair bladder & vagina	11.50	NA	NA	5.77	5.47	1.18	090
57250		A	Repair rectum & vagina	11.50	NA	NA	5.90	5.20	1.34	090
57260		A	Repair of vagina	14.44	NA	NA	7.03	6.22	1.71	090
57265		A	Extensive repair of vagina	15.94	NA	NA	7.57	6.90	1.86	090
57267		A	Insert mesh/pelvic flr addon	4.88	NA	NA	1.81	1.76	0.52	ZZZ
57268		A	Repair of bowel bulge	7.57	NA	NA	4.74	4.55	0.87	090
57270		A	Repair of bowel pouch	13.67	NA	NA	6.89	6.36	1.62	090
57280		A	Suspension of vagina	16.72	NA	NA	7.87	7.54	1.88	090
57282		A	Colpopexy, extraperitoneal	7.97	NA	NA	4.86	4.76	0.88	090
57283		A	Colpopexy, intraperitoneal	11.66	NA	NA	6.06	5.71	1.39	090
57284		A	Repair paravag defect, open	14.33	NA	NA	6.72	6.65	1.56	090

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57285		A	Repair paravag defect, vag	11.60	NA	NA	5.76	5.55	1.28	090
57287		A	Revise/remove sling repair	11.15	NA	NA	6.33	6.69	1.04	090
57288		A	Repair bladder defect	12.13	NA	NA	6.01	6.42	1.14	090
57289		A	Repair bladder & vagina	12.80	NA	NA	6.15	6.62	0.89	090
57291		A	Construction of vagina	8.64	NA	NA	4.92	4.93	1.04	090
57292		A	Construct vagina with graft	14.01	NA	NA	7.26	6.75	1.71	090
57295		A	Revise vag graft via vagina	7.82	NA	NA	4.45	4.47	0.85	090
57296		A	Revise vag graft, open abd	16.56	NA	NA	7.91	7.26	2.02	090
57300		A	Repair rectum-vagina fistula	8.71	NA	NA	5.50	4.84	1.08	090
57305		A	Repair rectum-vagina fistula	15.35	NA	NA	8.14	6.97	2.14	090
57307		A	Fistula repair & colostomy	17.17	NA	NA	9.38	7.85	2.63	090
57308		A	Fistula repair, transperine	10.59	NA	NA	5.80	5.34	1.27	090
57310		A	Repair urethrovaginal lesion	7.65	NA	NA	4.26	4.79	0.53	090
57311		A	Repair urethrovaginal lesion	8.91	NA	NA	4.67	5.25	0.62	090
57320		A	Repair bladder-vagina lesion	8.88	NA	NA	4.83	5.25	0.75	090
57330		A	Repair bladder-vagina lesion	13.21	NA	NA	6.05	6.71	0.92	090
57335		A	Repair vagina	20.02	NA	NA	9.72	9.24	2.44	090
57400		A	Dilation of vagina	2.27	NA	NA	1.14	1.10	0.28	000
57410		A	Pelvic examination	1.75	NA	NA	0.99	0.93	0.21	000
57415		A	Remove vaginal foreign body	2.49	NA	NA	1.59	1.56	0.26	010
57420		A	Exam of vagina w/scope	1.60	1.31	1.31	0.72	0.65	0.19	000
57421		A	Exam/biopsy of vag w/scope	2.20	1.71	1.71	0.96	0.86	0.27	000
57423		A	Repair paravag defect, lap	16.08	NA	NA	7.45	7.09	1.97	090
57425		A	Laparoscopy, surg, colpopexy	17.03	NA	NA	8.05	7.47	1.94	090
57426		A	Revise prosth vag graft lap	14.30	NA	NA	7.61	7.61	1.74	090
57452		A	Exam of cervix w/scope	1.50	1.23	1.24	0.85	0.80	0.17	000
57454		A	Bx/curett of cervix w/scope	2.33	1.56	1.53	1.17	1.08	0.28	000
57455		A	Biopsy of cervix w/scope	1.99	1.60	1.60	0.87	0.78	0.24	000
57456		A	Endocerv curettage w/scope	1.85	1.54	1.55	0.81	0.74	0.22	000
57460		A	Bx of cervix w/scope, leep	2.83	4.15	4.61	1.36	1.26	0.34	000
57461		A	Conz of cervix w/scope, leep	3.43	4.47	4.92	1.42	1.28	0.42	000
57500		A	Biopsy of cervix	1.20	1.94	2.12	0.74	0.68	0.14	000
57505		A	Endocervical curettage	1.19	1.34	1.38	1.11	1.11	0.14	010
57510		A	Cauterization of cervix	1.90	1.41	1.41	1.06	0.99	0.23	010
57511		A	Cryocautery of cervix	1.95	1.70	1.71	1.41	1.36	0.23	010
57513		A	Laser surgery of cervix	1.95	1.66	1.66	1.40	1.37	0.23	010
57520		A	Conization of cervix	4.11	3.55	3.60	2.80	2.72	0.49	090
57522		A	Conization of cervix	3.67	2.94	2.95	2.49	2.42	0.44	090
57530		A	Removal of cervix	5.27	NA	NA	3.48	3.37	0.63	090

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57531		A	Removal of cervix, radical	29.95	NA	NA	14.27	12.59	3.64	090
57540		A	Removal of residual cervix	13.29	NA	NA	6.71	6.18	1.61	090
57545		A	Remove cervix/repair pelvis	14.10	NA	NA	7.03	6.46	1.72	090
57550		A	Removal of residual cervix	6.34	NA	NA	4.04	3.89	0.76	090
57555		A	Remove cervix/repair vagina	9.94	NA	NA	5.45	5.08	1.20	090
57556		A	Remove cervix, repair bowel	9.36	NA	NA	5.18	5.02	1.03	090
57558		A	D&c of cervical stump	1.72	1.42	1.43	1.17	1.13	0.21	010
57700		A	Revision of cervix	4.35	NA	NA	3.51	3.46	0.51	090
57720		A	Revision of cervix	4.61	NA	NA	3.20	3.11	0.55	090
57800		A	Dilation of cervical canal	0.77	0.74	0.74	0.47	0.45	0.09	000
58100		A	Biopsy of uterus lining	1.53	1.22	1.23	0.73	0.66	0.18	000
58110		A	Bx done w/colposcopy add-on	0.77	0.46	0.45	0.30	0.27	0.09	ZZZ
58120		A	Dilation and curettage	3.59	2.88	2.74	1.98	1.84	0.43	010
58140		A	Myomectomy abdom method	15.79	NA	NA	7.73	6.99	2.03	090
58145		A	Myomectomy vag method	8.91	NA	NA	4.99	4.68	1.07	090
58146		A	Myomectomy abdom complex	20.34	NA	NA	9.36	8.58	2.48	090
58150		A	Total hysterectomy	17.31	NA	NA	8.28	7.45	2.12	090
58152		A	Total hysterectomy	21.86	NA	NA	10.18	9.26	2.69	090
58180		A	Partial hysterectomy	16.60	NA	NA	7.99	7.25	2.03	090
58200		A	Extensive hysterectomy	23.10	NA	NA	10.69	9.54	2.82	090
58210		A	Extensive hysterectomy	30.91	NA	NA	14.27	12.63	3.79	090
58240		A	Removal of pelvis contents	49.33	NA	NA	22.33	19.87	6.00	090
58260		A	Vaginal hysterectomy	14.15	NA	NA	7.09	6.53	1.72	090
58262		A	Vag hyst including t/o	15.94	NA	NA	7.76	7.12	1.94	090
58263		A	Vag hyst w/t/o & vag repair	17.23	NA	NA	8.28	7.60	2.10	090
58267		A	Vag hyst w/urinary repair	18.36	NA	NA	8.78	8.02	2.24	090
58270		A	Vag hyst w/enterocele repair	15.30	NA	NA	7.36	6.77	1.86	090
58275		A	Hysterectomy/revise vagina	17.03	NA	NA	8.26	7.57	2.08	090
58280		A	Hysterectomy/revise vagina	18.33	NA	NA	8.80	7.99	2.21	090
58285		A	Extensive hysterectomy	23.38	NA	NA	10.41	9.44	2.85	090
58290		A	Vag hyst complex	20.27	NA	NA	9.33	8.53	2.47	090
58291		A	Vag hyst incl t/o, complex	22.06	NA	NA	10.02	9.20	2.69	090
58292		A	Vag hyst t/o & repair, compl	23.35	NA	NA	10.52	9.59	2.85	090
58293		A	Vag hyst w/uro repair, compl	24.33	NA	NA	10.89	9.88	2.97	090
58294		A	Vag hyst w/enterocele, compl	21.55	NA	NA	9.82	8.91	2.63	090
58300		N	Insert intrauterine device	1.01	0.79	0.92	0.37	0.36	0.05	XXX
58301		A	Remove intrauterine device	1.27	1.12	1.14	0.49	0.43	0.15	000
58321		A	Artificial insemination	0.92	1.06	1.07	0.34	0.32	0.05	000
58322		A	Artificial insemination	1.10	1.05	1.09	0.42	0.37	0.13	000

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58323		A	Sperm washing	0.23	0.16	0.23	0.09	0.08	0.03	000
58340		A	Catheter for hysterography	0.88	1.98	2.33	0.60	0.61	0.10	000
58345		A	Reopen fallopian tube	4.70	NA	NA	2.46	2.33	0.57	010
58346		A	Insert heyman uteri capsule	7.56	NA	NA	4.49	4.10	0.44	090
58350		A	Reopen fallopian tube	1.06	1.33	1.39	0.92	0.92	0.13	010
58353		A	Endometr ablate, thermal	3.60	20.25	24.78	2.01	1.91	0.43	010
58356		A	Endometrial cryoablation	6.41	38.38	45.86	2.54	2.29	0.77	010
58400		A	Suspension of uterus	7.14	NA	NA	4.16	4.08	0.77	090
58410		A	Suspension of uterus	13.80	NA	NA	6.86	6.29	1.69	090
58520		A	Repair of ruptured uterus	13.48	NA	NA	7.37	6.28	2.08	090
58540		A	Revision of uterus	15.71	NA	NA	7.65	6.96	1.92	090
58541		A	Lsh, uterus 250 g or less	14.70	NA	NA	7.49	6.76	1.79	090
58542		A	Lsh w/t/o ut 250 g or less	16.56	NA	NA	8.21	7.38	2.02	090
58543		A	Lsh uterus above 250 g	16.87	NA	NA	8.37	7.47	2.06	090
58544		A	Lsh w/t/o uterus above 250 g	18.37	NA	NA	8.91	7.92	2.24	090
58545		A	Laparoscopic myomectomy	15.55	NA	NA	7.42	6.76	1.93	090
58546		A	Laparo-myomectomy, complex	19.94	NA	NA	9.05	8.25	2.43	090
58548		A	Lap radical hyst	31.63	NA	NA	14.82	12.69	3.83	090
58550		A	Laparo-asst vag hysterectomy	15.10	NA	NA	7.55	6.97	1.84	090
58552		A	Laparo-vag hyst incl t/o	16.91	NA	NA	8.25	7.56	2.06	090
58553		A	Laparo-vag hyst, complex	20.06	NA	NA	9.12	8.29	2.45	090
58554		A	Laparo-vag hyst w/t/o, compl	23.11	NA	NA	10.65	9.65	2.84	090
58555		A	Hysteroscopy, dx, sep proc	3.33	4.18	3.07	1.55	1.42	0.40	000
58558		A	Hysteroscopy, biopsy	4.74	5.12	3.81	2.12	1.95	0.58	000
58559		A	Hysteroscopy, lysis	6.16	NA	NA	2.67	2.44	0.75	000
58560		A	Hysteroscopy, resect septum	6.99	NA	NA	2.99	2.73	0.85	000
58561		A	Hysteroscopy, remove myoma	9.99	NA	NA	4.14	3.75	1.21	000
58562		A	Hysteroscopy, remove fb	5.20	5.06	3.78	2.27	2.09	0.63	000
58563		A	Hysteroscopy, ablation	6.16	33.31	40.14	2.66	2.44	0.75	000
58565		A	Hysteroscopy, sterilization	7.12	37.25	42.55	3.97	3.75	0.86	090
58570		A	Tlh, uterus 250 g or less	15.88	NA	NA	7.99	7.15	1.94	090
58571		A	Tlh w/t/o 250 g or less	17.69	NA	NA	8.83	7.77	2.17	090
58572		A	Tlh, uterus over 250 g	20.09	NA	NA	9.55	8.48	2.45	090
58573		A	Tlh w/t/o uterus over 250 g	23.11	NA	NA	10.94	9.51	2.82	090
58578		C	Laparo proc, uterus	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58579		C	Hysteroscope procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58600		A	Division of fallopian tube	5.91	NA	NA	3.40	3.18	0.71	090
58605		A	Division of fallopian tube	5.28	NA	NA	3.13	2.97	0.64	090
58611		A	Ligate oviduct(s) add-on	1.45	NA	NA	0.56	0.49	0.18	ZZZ

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58615		A	Occlude fallopian tube(s)	3.94	NA	NA	2.29	2.26	0.48	010
58660		A	Laparoscopy, lysis	11.59	NA	NA	5.63	5.12	1.49	090
58661		A	Laparoscopy, remove adnexa	11.35	NA	NA	5.17	4.70	1.40	010
58662		A	Laparoscopy, excise lesions	12.15	NA	NA	5.93	5.45	1.50	090
58670		A	Laparoscopy, tubal cautery	5.91	NA	NA	3.43	3.24	0.72	090
58671		A	Laparoscopy, tubal block	5.91	NA	NA	3.42	3.22	0.72	090
58672		A	Laparoscopy, fimbrioplasty	12.91	NA	NA	6.02	5.50	1.58	090
58673		A	Laparoscopy, salpingostomy	14.04	NA	NA	6.54	6.02	1.72	090
58679		C	Laparo proc, oviduct-ovary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58700		A	Removal of fallopian tube	12.95	NA	NA	6.84	6.13	1.75	090
58720		A	Removal of ovary/tube(s)	12.16	NA	NA	6.29	5.73	1.55	090
58740		A	Adhesiolysis tube, ovary	14.90	NA	NA	7.51	6.89	1.90	090
58750		A	Repair oviduct	15.64	NA	NA	7.53	6.94	1.91	090
58752		A	Revise ovarian tube(s)	15.64	NA	NA	7.39	7.06	0.78	090
58760		A	Fimbrioplasty	13.93	NA	NA	6.87	6.41	1.70	090
58770		A	Create new tubal opening	14.77	NA	NA	7.14	6.28	1.81	090
58800		A	Drainage of ovarian cyst(s)	4.62	3.43	3.46	2.98	2.91	0.55	090
58805		A	Drainage of ovarian cyst(s)	6.42	NA	NA	3.90	3.74	0.77	090
58820		A	Drain ovary abscess, open	4.70	NA	NA	3.24	3.16	0.56	090
58822		A	Drain ovary abscess, percut	11.81	NA	NA	6.84	6.04	1.82	090
58823		A	Drain pelvic abscess, percut	3.37	18.40	20.11	1.04	1.22	0.27	000
58825		A	Transposition, ovary(s)	11.78	NA	NA	6.05	5.60	1.43	090
58900		A	Biopsy of ovary(s)	6.59	NA	NA	4.64	3.96	1.00	090
58920		A	Partial removal of ovary(s)	11.95	NA	NA	6.03	5.50	1.45	090
58925		A	Removal of ovarian cyst(s)	12.43	NA	NA	6.47	5.86	1.61	090
58940		A	Removal of ovary(s)	8.22	NA	NA	4.86	4.40	1.09	090
58943		A	Removal of ovary(s)	19.52	NA	NA	9.33	8.33	2.54	090
58950		A	Resect ovarian malignancy	18.37	NA	NA	9.23	8.29	2.35	090
58951		A	Resect ovarian malignancy	24.26	NA	NA	11.31	10.06	3.02	090
58952		A	Resect ovarian malignancy	27.29	NA	NA	12.87	11.42	3.41	090
58953		A	Tah, rad dissect for debulk	34.13	NA	NA	15.64	13.81	4.25	090
58954		A	Tah rad debulk/lymph remove	37.13	NA	NA	16.84	14.88	4.59	090
58956		A	Bso, omentectomy w/tah	22.80	NA	NA	11.08	9.94	2.87	090
58957		A	Resect recurrent gyn mal	26.22	NA	NA	12.51	10.82	3.45	090
58958		A	Resect recur gyn mal w/lym	29.22	NA	NA	13.77	11.91	3.55	090
58960		A	Exploration of abdomen	15.79	NA	NA	7.97	7.21	2.00	090
58970		A	Retrieval of oocyte	3.52	2.20	2.08	1.63	1.46	0.18	000
58974		C	Transfer of embryo	0.00	0.00	0.00	0.00	0.00	0.00	000
58976		A	Transfer of embryo	3.82	2.52	2.56	1.74	1.72	0.19	000

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58999		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59000		A	Amniocentesis, diagnostic	1.30	1.70	1.83	0.66	0.62	0.27	000
59001		A	Amniocentesis, therapeutic	3.00	NA	NA	1.36	1.35	0.62	000
59012		A	Fetal cord puncture,prenatal	3.44	NA	NA	1.49	1.36	0.71	000
59015		A	Chorion biopsy	2.20	1.55	1.52	1.01	0.94	0.46	000
59020		A	Fetal contract stress test	0.66	1.03	1.01	NA	NA	0.13	000
59020	TC	A	Fetal contract stress test	0.00	0.78	0.79	NA	NA	0.01	000
59020	26	A	Fetal contract stress test	0.66	0.25	0.22	0.25	0.22	0.12	000
59025		A	Fetal non-stress test	0.53	0.62	0.60	NA	NA	0.10	000
59025	TC	A	Fetal non-stress test	0.00	0.42	0.42	NA	NA	0.01	000
59025	26	A	Fetal non-stress test	0.53	0.20	0.18	0.20	0.18	0.09	000
59030		A	Fetal scalp blood sample	1.99	NA	NA	0.73	0.67	0.10	000
59050		A	Fetal monitor w/report	0.89	NA	NA	0.34	0.30	0.18	XXX
59051		A	Fetal monitor/interpret only	0.74	NA	NA	0.28	0.25	0.15	XXX
59070		A	Transabdom amnioinfus w/us	5.24	4.64	4.84	2.29	2.19	1.09	000
59072		A	Umbilical cord occlud w/us	8.99	NA	NA	3.76	3.48	1.88	000
59074		A	Fetal fluid drainage w/us	5.24	4.88	4.49	2.45	2.18	1.09	000
59076		A	Fetal shunt placement, w/us	8.99	NA	NA	3.76	3.27	1.88	000
59100		A	Remove uterus lesion	13.37	NA	NA	6.82	6.22	2.77	090
59120		A	Treat ectopic pregnancy	12.67	NA	NA	6.55	6.08	2.62	090
59121		A	Treat ectopic pregnancy	12.74	NA	NA	6.50	6.05	2.64	090
59130		A	Treat ectopic pregnancy	15.08	NA	NA	7.35	6.75	0.75	090
59135		A	Treat ectopic pregnancy	14.92	NA	NA	7.23	7.11	0.74	090
59136		A	Treat ectopic pregnancy	14.25	NA	NA	7.03	6.45	2.95	090
59140		A	Treat ectopic pregnancy	5.94	NA	NA	3.84	3.51	0.29	090
59150		A	Treat ectopic pregnancy	12.29	NA	NA	6.34	5.85	2.54	090
59151		A	Treat ectopic pregnancy	12.11	NA	NA	6.01	5.58	2.51	090
59160		A	D & c after delivery	2.76	2.14	2.33	1.43	1.48	0.56	010
59200		A	Insert cervical dilator	0.79	0.93	1.00	0.30	0.27	0.16	000
59300		A	Episiotomy or vaginal repair	2.41	2.23	2.21	1.20	1.06	0.50	000
59320		A	Revision of cervix	2.48	NA	NA	1.22	1.14	0.51	000
59325		A	Revision of cervix	4.06	NA	NA	1.79	1.68	0.20	000
59350		A	Repair of uterus	4.94	NA	NA	1.87	1.59	1.02	000
59400		A	Obstetrical care	27.48	NA	NA	16.54	15.42	5.41	MMM
59409		A	Obstetrical care	13.48	NA	NA	5.21	4.60	2.70	MMM
59410		A	Obstetrical care	15.37	NA	NA	6.56	5.85	3.08	MMM
59412		A	Antepartum manipulation	1.71	NA	NA	0.80	0.74	0.35	MMM
59414		A	Deliver placenta	1.61	NA	NA	0.62	0.55	0.33	MMM
59425		A	Antepartum care only	6.50	4.78	4.49	2.49	2.02	1.23	MMM

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59426		A	Antepartum care only	11.57	8.75	8.18	4.42	3.57	2.17	MMM
59430		A	Care after delivery	2.13	1.26	1.19	0.93	0.84	0.42	MMM
59510		A	Cesarean delivery	31.07	NA	NA	18.56	17.41	6.27	MMM
59514		A	Cesarean delivery only	15.95	NA	NA	6.20	5.46	3.29	MMM
59515		A	Cesarean delivery	18.39	NA	NA	8.06	7.26	3.74	MMM
59525		A	Remove uterus after cesarean	8.53	NA	NA	3.28	2.91	1.79	ZZZ
59610		A	Vbac delivery	28.86	NA	NA	17.32	16.18	5.88	MMM
59612		A	Vbac delivery only	15.04	NA	NA	5.84	5.21	3.13	MMM
59614		A	Vbac care after delivery	16.64	NA	NA	6.86	6.18	3.46	MMM
59618		A	Attempted vbac delivery	32.51	NA	NA	19.20	18.09	6.62	MMM
59620		A	Attempted vbac delivery only	17.50	NA	NA	6.79	6.00	3.64	MMM
59622		A	Attempted vbac after care	19.83	NA	NA	8.75	7.94	4.10	MMM
59812		A	Treatment of miscarriage	4.44	3.34	3.14	2.70	2.55	0.90	090
59820		A	Care of miscarriage	4.84	4.27	4.28	3.74	3.63	0.97	090
59821		A	Treatment of miscarriage	5.09	4.09	4.08	3.52	3.40	1.03	090
59830		A	Treat uterus infection	6.59	NA	NA	3.95	3.79	1.35	090
59840		R	Abortion	3.01	2.24	2.16	2.03	1.96	0.58	010
59841		R	Abortion	5.65	3.57	3.40	3.07	2.86	1.15	010
59850		R	Abortion	5.90	NA	NA	3.32	3.28	0.30	090
59851		R	Abortion	5.92	NA	NA	3.70	3.57	1.23	090
59852		R	Abortion	8.23	NA	NA	5.05	5.03	0.41	090
59855		R	Abortion	6.43	NA	NA	3.60	3.41	1.32	090
59856		R	Abortion	7.79	NA	NA	4.01	3.76	1.61	090
59857		R	Abortion	9.33	NA	NA	4.47	4.45	0.47	090
59866		R	Abortion (mpr)	3.99	NA	NA	1.80	1.69	0.20	000
59870		A	Evacuate mole of uterus	6.57	NA	NA	4.80	4.75	1.33	090
59871		A	Remove cerclage suture	2.13	NA	NA	1.12	1.05	0.44	000
59897		C	Fetal invas px w/us	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59898		C	Laparo proc, ob care/deliver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59899		C	Maternity care procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60000		A	Drain thyroid/tongue cyst	1.81	2.37	2.23	1.96	1.86	0.16	010
60100		A	Biopsy of thyroid	1.56	1.23	1.36	0.49	0.55	0.12	000
60200		A	Remove thyroid lesion	10.02	NA	NA	6.90	6.14	1.23	090
60210		A	Partial thyroid excision	11.23	NA	NA	6.79	5.91	1.49	090
60212		A	Partial thyroid excision	16.43	NA	NA	9.33	8.05	2.20	090
60220		A	Partial removal of thyroid	12.37	NA	NA	7.44	6.44	1.55	090
60225		A	Partial removal of thyroid	14.79	NA	NA	8.99	7.81	1.90	090
60240		A	Removal of thyroid	16.22	NA	NA	8.64	7.48	2.14	090
60252		A	Removal of thyroid	22.01	NA	NA	11.89	10.24	2.80	090

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60254		A	Extensive thyroid surgery	28.42	NA	NA	15.19	13.28	3.28	090
60260		A	Repeat thyroid surgery	18.26	NA	NA	9.97	8.63	2.26	090
60270		A	Removal of thyroid	23.20	NA	NA	11.88	10.63	3.16	090
60271		A	Removal of thyroid	17.62	NA	NA	9.65	8.42	2.18	090
60280		A	Remove thyroid duct lesion	6.16	NA	NA	5.46	4.89	0.60	090
60281		A	Remove thyroid duct lesion	8.82	NA	NA	6.79	5.91	0.81	090
60300		A	Aspir/inj thyroid cyst	0.97	1.81	1.83	0.31	0.33	0.08	000
60500		A	Explore parathyroid glands	16.78	NA	NA	9.15	7.83	2.34	090
60502		A	Re-explore parathyroids	21.15	NA	NA	11.31	9.73	2.99	090
60505		A	Explore parathyroid glands	23.06	NA	NA	12.52	10.91	3.12	090
60512		A	Autotransplant parathyroid	4.44	NA	NA	1.76	1.50	0.60	ZZZ
60520		A	Removal of thymus gland	17.16	NA	NA	8.85	7.95	2.50	090
60521		A	Removal of thymus gland	19.18	NA	NA	9.16	9.11	3.28	090
60522		A	Removal of thymus gland	23.48	NA	NA	10.95	10.77	3.94	090
60540		A	Explore adrenal gland	18.02	NA	NA	8.71	8.60	2.18	090
60545		A	Explore adrenal gland	20.93	NA	NA	9.89	9.38	2.66	090
60600		A	Remove carotid body lesion	25.09	NA	NA	10.83	10.23	3.82	090
60605		A	Remove carotid body lesion	31.96	NA	NA	19.07	14.05	2.97	090
60650		A	Laparoscopy adrenalectomy	20.73	NA	NA	9.48	8.82	2.70	090
60659		C	Laparo proc, endocrine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60699		C	Endocrine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
6070F		I	Pt asked/cnsld aed effects	0.00	0.00	0.00	0.00	0.00	0.00	XXX
61000		A	Remove cranial cavity fluid	1.58	NA	NA	1.31	1.20	0.11	000
61001		A	Remove cranial cavity fluid	1.49	NA	NA	1.99	1.37	0.39	000
61020		A	Remove brain cavity fluid	1.51	NA	NA	1.69	1.60	0.36	000
61026		A	Injection into brain canal	1.69	NA	NA	1.43	1.39	0.28	000
61050		A	Remove brain canal fluid	1.51	NA	NA	1.16	1.21	0.10	000
61055		A	Injection into brain canal	2.10	NA	NA	1.31	1.38	0.21	000
61070		A	Brain canal shunt procedure	0.89	NA	NA	1.19	1.12	0.14	000
61105		A	Twist drill hole	5.45	NA	NA	5.15	4.70	1.37	090
61107		A	Drill skull for implantation	4.99	NA	NA	2.31	2.18	1.27	000
61108		A	Drill skull for drainage	11.64	NA	NA	9.39	8.51	2.96	090
61120		A	Burr hole for puncture	9.60	NA	NA	7.74	6.95	2.48	090
61140		A	Pierce skull for biopsy	17.23	NA	NA	11.92	10.98	4.40	090
61150		A	Pierce skull for drainage	18.90	NA	NA	12.47	11.34	4.89	090
61151		A	Pierce skull for drainage	13.49	NA	NA	9.55	8.56	3.49	090
61154		A	Pierce skull & remove clot	17.07	NA	NA	12.36	11.23	4.39	090
61156		A	Pierce skull for drainage	17.45	NA	NA	11.30	10.53	4.52	090
61210		A	Pierce skull, implant device	5.83	NA	NA	2.69	2.54	1.51	000

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61215		A	Insert brain-fluid device	5.85	NA	NA	5.90	5.36	1.49	090
61250		A	Pierce skull & explore	11.49	NA	NA	8.62	7.66	2.97	090
61253		A	Pierce skull & explore	13.49	NA	NA	8.37	7.72	1.24	090
61304		A	Open skull for exploration	23.41	NA	NA	14.76	13.53	5.89	090
61305		A	Open skull for exploration	28.64	NA	NA	17.87	16.38	7.42	090
61312		A	Open skull for drainage	30.17	NA	NA	17.99	16.45	7.80	090
61313		A	Open skull for drainage	28.09	NA	NA	17.85	16.33	7.24	090
61314		A	Open skull for drainage	25.90	NA	NA	16.49	15.01	6.68	090
61315		A	Open skull for drainage	29.65	NA	NA	18.24	16.81	7.69	090
61316		A	Implt cran bone flap to abdo	1.39	NA	NA	0.64	0.59	0.36	ZZZ
61320		A	Open skull for drainage	27.42	NA	NA	16.69	15.48	7.00	090
61321		A	Open skull for drainage	30.53	NA	NA	18.75	16.79	7.91	090
61322		A	Decompressive craniotomy	34.26	NA	NA	20.71	18.51	8.82	090
61323		A	Decompressive lobectomy	35.06	NA	NA	20.16	18.26	9.01	090
61330		A	Decompress eye socket	25.30	NA	NA	14.76	13.45	6.55	090
61332		A	Explore/biopsy eye socket	28.60	NA	NA	17.32	15.06	7.42	090
61333		A	Explore orbit/remove lesion	29.27	NA	NA	19.51	15.92	7.59	090
61334		A	Explore orbit/remove object	19.60	NA	NA	13.13	10.42	5.08	090
61340		A	Subtemporal decompression	20.11	NA	NA	13.37	12.08	5.21	090
61343		A	Incise skull (press relief)	31.86	NA	NA	19.09	17.55	8.19	090
61345		A	Relieve cranial pressure	29.23	NA	NA	17.97	16.54	7.58	090
61440		A	Incise skull for surgery	28.66	NA	NA	17.70	16.18	7.43	090
61450		A	Incise skull for surgery	27.69	NA	NA	16.80	15.28	7.18	090
61458		A	Incise skull for brain wound	28.84	NA	NA	17.62	16.33	7.40	090
61460		A	Incise skull for surgery	30.24	NA	NA	18.44	16.48	7.84	090
61470		A	Incise skull for surgery	27.62	NA	NA	16.76	15.38	7.17	090
61480		A	Incise skull for surgery	28.05	NA	NA	12.06	12.42	1.41	090
61490		A	Incise skull for surgery	27.22	NA	NA	16.58	15.33	7.06	090
61500		A	Removal of skull lesion	19.18	NA	NA	12.80	11.61	4.18	090
61501		A	Remove infected skull bone	16.35	NA	NA	11.51	10.33	3.36	090
61510		A	Removal of brain lesion	30.83	NA	NA	19.76	18.18	7.93	090
61512		A	Remove brain lining lesion	37.14	NA	NA	21.91	20.26	9.59	090
61514		A	Removal of brain abscess	27.23	NA	NA	16.89	15.57	7.01	090
61516		A	Removal of brain lesion	26.58	NA	NA	16.28	15.15	6.65	090
61517		A	Implt brain chemotx add-on	1.38	NA	NA	0.64	0.60	0.35	ZZZ
61518		A	Removal of brain lesion	39.89	NA	NA	24.04	22.06	10.32	090
61519		A	Remove brain lining lesion	43.43	NA	NA	24.77	22.93	11.20	090
61520		A	Removal of brain lesion	57.09	NA	NA	31.41	29.27	12.98	090
61521		A	Removal of brain lesion	46.99	NA	NA	26.63	24.41	12.19	090

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61522		A	Removal of brain abscess	31.54	NA	NA	19.05	17.60	8.17	090
61524		A	Removal of brain lesion	29.89	NA	NA	18.28	16.63	7.75	090
61526		A	Removal of brain lesion	54.08	NA	NA	28.99	26.55	14.03	090
61530		A	Removal of brain lesion	45.56	NA	NA	25.57	22.99	11.83	090
61531		A	Implant brain electrodes	16.41	NA	NA	11.91	10.91	4.24	090
61533		A	Implant brain electrodes	21.46	NA	NA	13.77	12.65	5.55	090
61534		A	Removal of brain lesion	23.01	NA	NA	15.07	13.83	5.96	090
61535		A	Remove brain electrodes	13.15	NA	NA	10.03	9.15	3.39	090
61536		A	Removal of brain lesion	37.72	NA	NA	21.92	20.37	9.79	090
61537		A	Removal of brain tissue	36.45	NA	NA	20.40	18.27	9.41	090
61538		A	Removal of brain tissue	39.45	NA	NA	21.55	19.47	10.25	090
61539		A	Removal of brain tissue	34.28	NA	NA	20.32	18.48	8.89	090
61540		A	Removal of brain tissue	31.43	NA	NA	19.08	17.64	8.14	090
61541		A	Incision of brain tissue	30.94	NA	NA	18.77	17.18	8.02	090
61542		A	Removal of brain tissue	33.16	NA	NA	19.67	18.32	8.60	090
61543		A	Removal of brain tissue	31.31	NA	NA	18.94	16.98	8.11	090
61544		A	Remove & treat brain lesion	27.36	NA	NA	16.64	13.22	7.10	090
61545		A	Excision of brain tumor	46.43	NA	NA	27.22	24.87	12.04	090
61546		A	Removal of pituitary gland	33.44	NA	NA	19.93	18.24	8.67	090
61548		A	Removal of pituitary gland	23.37	NA	NA	14.11	12.92	4.81	090
61550		A	Release of skull seams	15.59	NA	NA	7.92	8.64	0.77	090
61552		A	Release of skull seams	20.40	NA	NA	9.55	11.26	1.02	090
61556		A	Incise skull/sutures	24.09	NA	NA	15.34	13.53	6.25	090
61557		A	Incise skull/sutures	23.31	NA	NA	15.61	14.54	6.03	090
61558		A	Excision of skull/sutures	26.50	NA	NA	16.96	15.64	6.85	090
61559		A	Excision of skull/sutures	34.02	NA	NA	15.05	18.32	1.71	090
61563		A	Excision of skull tumor	28.44	NA	NA	17.36	16.03	7.38	090
61564		A	Excision of skull tumor	34.74	NA	NA	20.93	19.38	9.01	090
61566		A	Removal of brain tissue	32.45	NA	NA	19.55	18.24	8.42	090
61567		A	Incision of brain tissue	37.00	NA	NA	22.29	20.87	9.59	090
61570		A	Remove foreign body, brain	26.51	NA	NA	16.70	15.04	6.86	090
61571		A	Incise skull for brain wound	28.42	NA	NA	17.59	16.28	7.37	090
61575		A	Skull base/brainstem surgery	36.56	NA	NA	21.38	18.81	9.48	090
61576		A	Skull base/brainstem surgery	55.31	NA	NA	36.00	34.47	5.14	090
61580		A	Craniofacial approach, skull	34.51	NA	NA	27.89	25.34	4.26	090
61581		A	Craniofacial approach, skull	39.13	NA	NA	31.93	28.28	3.62	090
61582		A	Craniofacial approach, skull	35.14	NA	NA	35.92	31.98	9.09	090
61583		A	Craniofacial approach, skull	38.50	NA	NA	29.12	27.16	9.36	090
61584		A	Orbitocranial approach/skull	37.70	NA	NA	28.50	26.74	9.18	090

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61585		A	Orbitocranial approach/skull	42.57	NA	NA	32.61	27.79	11.05	090
61586		A	Resect nasopharynx, skull	27.48	NA	NA	29.62	24.48	7.10	090
61590		A	Infratemporal approach/skull	47.04	NA	NA	31.59	28.31	6.09	090
61591		A	Infratemporal approach/skull	47.02	NA	NA	31.43	28.50	6.94	090
61592		A	Orbitocranial approach/skull	43.08	NA	NA	30.88	28.85	10.48	090
61595		A	Transtemporal approach/skull	33.74	NA	NA	25.63	23.33	5.16	090
61596		A	Transcochlear approach/skull	39.43	NA	NA	26.02	23.75	3.66	090
61597		A	Transcondylar approach/skull	40.82	NA	NA	28.02	24.96	10.60	090
61598		A	Transpetrosal approach/skull	36.53	NA	NA	29.28	24.15	9.48	090
61600		A	Resect/excise cranial lesion	30.01	NA	NA	24.16	21.48	4.49	090
61601		A	Resect/excise cranial lesion	31.14	NA	NA	24.91	22.99	7.36	090
61605		A	Resect/excise cranial lesion	32.57	NA	NA	24.50	21.97	3.56	090
61606		A	Resect/excise cranial lesion	42.05	NA	NA	28.76	26.81	9.89	090
61607		A	Resect/excise cranial lesion	40.93	NA	NA	26.99	24.19	10.63	090
61608		A	Resect/excise cranial lesion	45.54	NA	NA	30.00	27.94	11.13	090
61609		A	Transect artery, sinus	9.88	NA	NA	4.76	4.03	2.58	ZZZ
61610		A	Transect artery, sinus	29.63	NA	NA	13.79	12.74	7.71	ZZZ
61611		A	Transect artery, sinus	7.41	NA	NA	2.71	3.10	0.37	ZZZ
61612		A	Transect artery, sinus	27.84	NA	NA	10.16	10.93	1.41	ZZZ
61613		A	Remove aneurysm, sinus	45.03	NA	NA	31.03	28.08	11.69	090
61615		A	Resect/excise lesion, skull	35.77	NA	NA	24.39	23.11	3.32	090
61616		A	Resect/excise lesion, skull	46.74	NA	NA	32.02	29.42	10.42	090
61618		A	Repair dura	18.69	NA	NA	12.31	11.17	4.16	090
61619		A	Repair dura	22.10	NA	NA	13.72	12.49	4.58	090
61623		A	Endovasc tempory vessel occl	9.95	NA	NA	3.72	4.00	1.33	000
61624		A	Transcath occlusion, cns	20.12	NA	NA	7.07	7.69	2.73	000
61626		A	Transcath occlusion, non-cns	16.60	NA	NA	5.20	6.15	1.55	000
61630		R	Intracranial angioplasty	22.07	NA	NA	9.07	9.78	3.03	XXX
61635		R	Intracran angioplsty w/stent	24.28	NA	NA	9.67	10.56	2.94	XXX
61640		N	Dilate ic vasospasm, init	12.32	NA	NA	4.50	4.29	0.62	000
61641		N	Dilate ic vasospasm add-on	4.33	NA	NA	1.58	1.51	0.22	ZZZ
61642		N	Dilate ic vasospasm add-on	8.66	NA	NA	3.16	3.02	0.43	ZZZ
61680		A	Intracranial vessel surgery	32.55	NA	NA	19.78	18.32	8.44	090
61682		A	Intracranial vessel surgery	63.41	NA	NA	33.11	31.03	16.48	090
61684		A	Intracranial vessel surgery	41.64	NA	NA	24.14	21.84	10.80	090
61686		A	Intracranial vessel surgery	67.50	NA	NA	36.55	34.02	17.52	090
61690		A	Intracranial vessel surgery	31.34	NA	NA	19.23	17.59	8.11	090
61692		A	Intracranial vessel surgery	54.59	NA	NA	30.06	27.60	14.17	090
61697		A	Brain aneurysm repr, complx	63.40	NA	NA	34.18	31.18	16.30	090

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61698		A	Brain aneurysm repr, complx	69.63	NA	NA	37.54	33.33	18.08	090
61700		A	Brain aneurysm repr, simple	50.62	NA	NA	28.52	26.73	13.04	090
61702		A	Inner skull vessel surgery	60.04	NA	NA	33.08	29.61	15.59	090
61703		A	Clamp neck artery	18.80	NA	NA	12.66	11.69	4.87	090
61705		A	Revise circulation to head	38.10	NA	NA	22.10	19.69	9.89	090
61708		A	Revise circulation to head	37.20	NA	NA	17.70	16.10	2.22	090
61710		A	Revise circulation to head	31.29	NA	NA	13.48	14.76	4.71	090
61711		A	Fusion of skull arteries	38.23	NA	NA	21.67	20.11	9.92	090
61720		A	Incise skull/brain surgery	17.62	NA	NA	11.78	9.85	4.56	090
61735		A	Incise skull/brain surgery	22.35	NA	NA	14.44	11.91	5.79	090
61750		A	Incise skull/brain biopsy	19.83	NA	NA	12.70	11.71	5.11	090
61751		A	Brain biopsy w/ct/mr guide	18.79	NA	NA	13.00	12.04	4.82	090
61760		A	Implant brain electrodes	22.39	NA	NA	14.18	12.41	5.79	090
61770		A	Incise skull for treatment	23.19	NA	NA	13.88	12.27	5.92	090
61790		A	Treat trigeminal nerve	11.60	NA	NA	8.70	7.71	2.92	090
61791		A	Treat trigeminal tract	15.41	NA	NA	10.02	9.47	3.74	090
61795		A	Brain surgery using computer	4.03	NA	NA	1.89	1.74	0.76	ZZZ
61796		A	Srs, cranial lesion simple	13.93	NA	NA	8.99	7.51	0.54	090
61797		A	Srs, cran les simple, addl	3.48	NA	NA	1.55	1.42	0.17	ZZZ
61798		A	Srs, cranial lesion complex	19.85	NA	NA	11.62	8.18	0.54	090
61799		A	Srs, cran les complex, addl	4.81	NA	NA	2.14	1.95	0.24	ZZZ
61800		A	Apply srs headframe add-on	2.25	NA	NA	1.25	1.16	0.11	ZZZ
61850		A	Implant neuroelectrodes	13.34	NA	NA	9.40	8.69	3.45	090
61860		A	Implant neuroelectrodes	22.26	NA	NA	13.94	12.88	5.77	090
61863		A	Implant neuroelectrode	20.71	NA	NA	14.08	13.04	5.34	090
61864		A	Implant neuroelectrde, addl	4.49	NA	NA	2.09	1.98	1.16	ZZZ
61867		A	Implant neuroelectrode	33.03	NA	NA	19.80	18.33	8.55	090
61868		A	Implant neuroelectrde, addl	7.91	NA	NA	3.69	3.48	2.06	ZZZ
61870		A	Implant neuroelectrodes	16.34	NA	NA	11.06	10.32	4.23	090
61875		A	Implant neuroelectrodes	16.46	NA	NA	7.67	9.27	0.82	090
61880		A	Revise/remove neuroelectrode	6.95	NA	NA	6.30	5.60	1.78	090
61885		A	Insrt/redo neurostim 1 array	7.57	NA	NA	8.23	7.33	1.83	090
61886		A	Implant neurostim arrays	9.93	NA	NA	9.72	8.76	2.50	090
61888		A	Revise/remove neuroreceiver	5.23	NA	NA	3.89	3.71	1.24	010
62000		A	Treat skull fracture	13.93	NA	NA	9.94	7.68	3.60	090
62005		A	Treat skull fracture	17.63	NA	NA	11.79	10.55	4.56	090
62010		A	Treatment of head injury	21.43	NA	NA	13.63	12.57	5.55	090
62100		A	Repair brain fluid leakage	23.53	NA	NA	14.49	13.15	5.42	090
62115		A	Reduction of skull defect	22.91	NA	NA	10.84	9.08	1.14	090

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62116		A	Reduction of skull defect	25.02	NA	NA	16.02	14.77	6.48	090
62117		A	Reduction of skull defect	28.35	NA	NA	15.86	15.58	2.63	090
62120		A	Repair skull cavity lesion	24.59	NA	NA	19.63	18.57	2.28	090
62121		A	Incise skull repair	23.03	NA	NA	19.58	16.13	5.97	090
62140		A	Repair of skull defect	14.55	NA	NA	9.94	9.10	3.42	090
62141		A	Repair of skull defect	16.07	NA	NA	10.81	9.91	3.82	090
62142		A	Remove skull plate/flap	11.83	NA	NA	8.89	8.13	2.93	090
62143		A	Replace skull plate/flap	14.15	NA	NA	10.00	9.09	3.60	090
62145		A	Repair of skull & brain	20.09	NA	NA	12.52	11.65	5.21	090
62146		A	Repair of skull with graft	17.28	NA	NA	11.63	10.33	4.47	090
62147		A	Repair of skull with graft	20.67	NA	NA	13.20	11.97	5.36	090
62148		A	Retr bone flap to fix skull	2.00	NA	NA	0.93	0.85	0.52	ZZZ
62160		A	Neuroendoscopy add-on	3.00	NA	NA	1.39	1.32	0.77	ZZZ
62161		A	Dissect brain w/scope	21.23	NA	NA	14.02	12.81	5.50	090
62162		A	Remove colloid cyst w/scope	26.80	NA	NA	16.94	15.74	6.95	090
62163		A	Neuroendoscopy w/fb removal	16.53	NA	NA	11.83	10.99	4.27	090
62164		A	Remove brain tumor w/scope	29.43	NA	NA	18.93	16.84	7.62	090
62165		A	Remove pituit tumor w/scope	23.23	NA	NA	14.47	13.31	4.60	090
62180		A	Establish brain cavity shunt	22.58	NA	NA	14.46	13.33	5.85	090
62190		A	Establish brain cavity shunt	12.17	NA	NA	9.25	8.40	3.14	090
62192		A	Establish brain cavity shunt	13.35	NA	NA	9.53	8.56	3.32	090
62194		A	Replace/irrigate catheter	5.78	NA	NA	5.20	3.78	0.32	010
62200		A	Establish brain cavity shunt	19.29	NA	NA	12.56	11.54	4.99	090
62201		A	Brain cavity shunt w/scope	16.04	NA	NA	11.86	10.79	4.12	090
62220		A	Establish brain cavity shunt	14.10	NA	NA	9.65	8.75	3.47	090
62223		A	Establish brain cavity shunt	14.05	NA	NA	10.61	9.68	3.46	090
62225		A	Replace/irrigate catheter	6.19	NA	NA	5.93	5.30	1.58	090
62230		A	Replace/revise brain shunt	11.43	NA	NA	8.21	7.49	2.86	090
62252		A	Csf shunt reprogram	0.74	1.78	1.71	NA	NA	0.18	XXX
62252	TC	A	Csf shunt reprogram	0.00	1.44	1.39	NA	NA	0.01	XXX
62252	26	A	Csf shunt reprogram	0.74	0.34	0.32	0.34	0.32	0.17	XXX
62256		A	Remove brain cavity shunt	7.38	NA	NA	6.50	5.94	1.89	090
62258		A	Replace brain cavity shunt	15.64	NA	NA	10.59	9.70	3.91	090
62263		A	Epidural lysis mult sessions	6.54	12.48	10.60	4.37	3.37	0.37	010
62264		A	Epidural lysis on single day	4.42	6.69	5.86	2.08	1.51	0.26	010
62267		A	Interdiscal perq aspir, dx	3.00	4.18	3.64	1.49	1.26	0.15	000
62268		A	Drain spinal cord cyst	4.73	5.68	6.70	1.89	1.96	0.34	000
62269		A	Needle biopsy, spinal cord	5.01	5.45	7.23	1.66	1.81	0.41	000
62270		A	Spinal fluid tap, diagnostic	1.37	2.41	2.54	0.59	0.60	0.16	000

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62272		A	Drain cerebro spinal fluid	1.35	3.47	3.32	0.70	0.68	0.23	000
62273		A	Inject epidural patch	2.15	2.21	2.06	0.83	0.69	0.14	000
62280		A	Treat spinal cord lesion	2.63	5.25	5.10	1.44	1.21	0.36	010
62281		A	Treat spinal cord lesion	2.66	5.10	4.66	1.47	1.14	0.20	010
62282		A	Treat spinal canal lesion	2.33	4.92	5.08	1.44	1.17	0.21	010
62284		A	Injection for myelogram	1.54	3.52	4.00	0.66	0.73	0.13	000
62287		A	Percutaneous diskectomy	9.03	NA	NA	5.29	4.93	0.59	090
62290		A	Inject for spine disk x-ray	3.00	5.51	5.33	1.55	1.35	0.21	000
62291		A	Inject for spine disk x-ray	2.91	5.25	4.91	1.52	1.28	0.19	000
62292		A	Injection into disk lesion	9.24	NA	NA	4.26	3.27	0.54	090
62294		A	Injection into spinal artery	12.87	NA	NA	3.30	5.86	0.73	090
62310		A	Inject spine c/t	1.91	4.21	3.73	0.95	0.71	0.12	000
62311		A	Inject spine l/s (cd)	1.54	3.57	3.38	0.79	0.63	0.10	000
62318		A	Inject spine w/cath, c/t	2.04	3.91	3.85	0.62	0.53	0.12	000
62319		A	Inject spine w/cath l/s (cd)	1.87	3.70	3.50	0.67	0.55	0.12	000
62350		A	Implant spinal canal cath	6.05	NA	NA	4.07	3.39	0.75	010
62351		A	Implant spinal canal cath	11.66	NA	NA	9.35	8.14	2.43	090
62355		A	Remove spinal canal catheter	4.35	NA	NA	3.35	2.80	0.53	010
62360		A	Insert spine infusion device	4.33	NA	NA	3.44	2.82	0.63	010
62361		A	Implant spine infusion pump	5.65	NA	NA	4.23	3.82	0.79	010
62362		A	Implant spine infusion pump	6.10	NA	NA	4.26	3.70	0.88	010
62365		A	Remove spine infusion device	4.65	NA	NA	3.64	3.17	0.64	010
62367		A	Analyze spine infusion pump	0.48	0.61	0.52	0.19	0.14	0.04	XXX
62368		A	Analyze spine infusion pump	0.75	0.84	0.68	0.31	0.22	0.06	XXX
63001		A	Removal of spinal lamina	17.61	NA	NA	11.49	10.48	4.10	090
63003		A	Removal of spinal lamina	17.74	NA	NA	11.55	10.56	4.05	090
63005		A	Removal of spinal lamina	16.43	NA	NA	11.70	10.67	3.64	090
63011		A	Removal of spinal lamina	15.91	NA	NA	10.84	9.62	2.89	090
63012		A	Removal of spinal lamina	16.85	NA	NA	11.49	10.59	3.67	090
63015		A	Removal of spinal lamina	20.85	NA	NA	13.92	12.76	5.05	090
63016		A	Removal of spinal lamina	22.03	NA	NA	13.90	12.71	4.89	090
63017		A	Removal of spinal lamina	17.33	NA	NA	12.17	11.15	3.99	090
63020		A	Neck spine disk surgery	16.20	NA	NA	11.59	10.59	3.63	090
63030		A	Low back disk surgery	13.18	NA	NA	10.07	9.19	2.78	090
63035		A	Spinal disk surgery add-on	3.15	NA	NA	1.51	1.42	0.64	ZZZ
63040		A	Laminotomy, single cervical	20.31	NA	NA	13.15	12.01	4.53	090
63042		A	Laminotomy, single lumbar	18.76	NA	NA	12.68	11.63	3.73	090
63043		C	Laminotomy, addl cervical	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63044		C	Laminotomy, addl lumbar	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ

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63045		A	Removal of spinal lamina	17.95	NA	NA	12.12	11.11	4.12	090
63046		A	Removal of spinal lamina	17.25	NA	NA	11.70	10.71	3.70	090
63047		A	Removal of spinal lamina	15.37	NA	NA	11.09	10.20	3.16	090
63048		A	Remove spinal lamina add-on	3.47	NA	NA	1.66	1.54	0.72	ZZZ
63050		A	Cervical laminoplasty	22.01	NA	NA	14.03	12.92	5.70	090
63051		A	C-laminoplasty w/graft/plate	25.51	NA	NA	15.74	14.36	5.23	090
63055		A	Decompress spinal cord	23.55	NA	NA	14.77	13.63	5.53	090
63056		A	Decompress spinal cord	21.86	NA	NA	13.77	12.60	4.46	090
63057		A	Decompress spine cord add-on	5.25	NA	NA	2.51	2.35	1.09	ZZZ
63064		A	Decompress spinal cord	26.22	NA	NA	15.96	14.53	5.73	090
63066		A	Decompress spine cord add-on	3.26	NA	NA	1.52	1.45	0.84	ZZZ
63075		A	Neck spine disk surgery	19.60	NA	NA	13.03	12.09	4.41	090
63076		A	Neck spine disk surgery	4.04	NA	NA	1.92	1.81	0.90	ZZZ
63077		A	Spine disk surgery, thorax	22.88	NA	NA	13.59	12.56	4.23	090
63078		A	Spine disk surgery, thorax	3.28	NA	NA	1.56	1.45	0.55	ZZZ
63081		A	Removal of vertebral body	26.10	NA	NA	16.16	14.84	5.69	090
63082		A	Remove vertebral body add-on	4.36	NA	NA	2.08	1.96	0.95	ZZZ
63085		A	Removal of vertebral body	29.47	NA	NA	16.62	15.23	5.72	090
63086		A	Remove vertebral body add-on	3.19	NA	NA	1.47	1.39	0.64	ZZZ
63087		A	Removal of vertebral body	37.53	NA	NA	20.70	19.13	7.04	090
63088		A	Remove vertebral body add-on	4.32	NA	NA	2.05	1.94	0.76	ZZZ
63090		A	Removal of vertebral body	30.93	NA	NA	17.68	16.14	5.19	090
63091		A	Remove vertebral body add-on	3.03	NA	NA	1.42	1.33	0.49	ZZZ
63101		A	Removal of vertebral body	34.10	NA	NA	20.89	19.23	7.66	090
63102		A	Removal of vertebral body	34.10	NA	NA	20.71	19.00	6.20	090
63103		A	Remove vertebral body add-on	4.82	NA	NA	2.29	2.18	0.93	ZZZ
63170		A	Incise spinal cord tract(s)	22.21	NA	NA	14.66	13.01	5.75	090
63172		A	Drainage of spinal cyst	19.76	NA	NA	12.66	11.69	5.12	090
63173		A	Drainage of spinal cyst	24.31	NA	NA	15.64	14.38	6.29	090
63180		A	Revise spinal cord ligaments	20.53	NA	NA	10.37	10.93	5.32	090
63182		A	Revise spinal cord ligaments	22.82	NA	NA	14.94	11.48	5.91	090
63185		A	Incise spinal column/nerves	16.49	NA	NA	11.87	10.18	4.26	090
63190		A	Incise spinal column/nerves	18.89	NA	NA	12.59	11.45	3.09	090
63191		A	Incise spinal column/nerves	18.92	NA	NA	13.93	9.03	2.69	090
63194		A	Incise spinal column & cord	22.10	NA	NA	13.28	12.47	2.05	090
63195		A	Incise spinal column & cord	21.64	NA	NA	13.94	12.48	5.61	090
63196		A	Incise spinal column & cord	25.27	NA	NA	11.24	13.51	1.26	090
63197		A	Incise spinal column & cord	24.08	NA	NA	15.53	14.18	6.23	090
63198		A	Incise spinal column & cord	29.90	NA	NA	13.12	11.96	1.50	090

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63199		A	Incise spinal column & cord	31.47	NA	NA	13.69	15.60	1.58	090
63200		A	Release of spinal cord	21.44	NA	NA	14.05	12.73	5.48	090
63250		A	Revise spinal cord vessels	43.86	NA	NA	24.78	22.52	11.38	090
63251		A	Revise spinal cord vessels	44.64	NA	NA	25.54	23.47	11.58	090
63252		A	Revise spinal cord vessels	44.63	NA	NA	25.53	23.40	11.57	090
63265		A	Excise intraspinal lesion	23.82	NA	NA	15.24	13.97	5.83	090
63266		A	Excise intraspinal lesion	24.68	NA	NA	15.63	14.22	6.05	090
63267		A	Excise intraspinal lesion	19.45	NA	NA	13.08	11.99	4.51	090
63268		A	Excise intraspinal lesion	20.02	NA	NA	13.68	12.15	5.18	090
63270		A	Excise intraspinal lesion	29.80	NA	NA	18.24	16.59	7.72	090
63271		A	Excise intraspinal lesion	29.92	NA	NA	18.17	16.67	7.63	090
63272		A	Excise intraspinal lesion	27.50	NA	NA	16.98	15.57	6.83	090
63273		A	Excise intraspinal lesion	26.47	NA	NA	16.69	14.54	6.85	090
63275		A	Biopsy/excise spinal tumor	25.86	NA	NA	16.16	14.75	6.35	090
63276		A	Biopsy/excise spinal tumor	25.69	NA	NA	16.02	14.70	6.28	090
63277		A	Biopsy/excise spinal tumor	22.39	NA	NA	14.41	13.19	5.05	090
63278		A	Biopsy/excise spinal tumor	22.12	NA	NA	14.66	13.08	5.73	090
63280		A	Biopsy/excise spinal tumor	30.29	NA	NA	18.75	17.35	7.81	090
63281		A	Biopsy/excise spinal tumor	29.99	NA	NA	18.49	17.12	7.69	090
63282		A	Biopsy/excise spinal tumor	28.15	NA	NA	17.69	16.35	7.19	090
63283		A	Biopsy/excise spinal tumor	26.76	NA	NA	17.21	15.61	6.93	090
63285		A	Biopsy/excise spinal tumor	38.05	NA	NA	22.39	20.30	9.87	090
63286		A	Biopsy/excise spinal tumor	37.62	NA	NA	22.15	20.39	9.53	090
63287		A	Biopsy/excise spinal tumor	40.08	NA	NA	23.41	21.39	10.40	090
63290		A	Biopsy/excise spinal tumor	40.82	NA	NA	23.76	21.69	10.59	090
63295		A	Repair of laminectomy defect	5.25	NA	NA	2.44	2.19	1.36	ZZZ
63300		A	Removal of vertebral body	26.80	NA	NA	16.41	15.04	6.26	090
63301		A	Removal of vertebral body	31.57	NA	NA	19.45	16.63	8.18	090
63302		A	Removal of vertebral body	31.15	NA	NA	19.26	16.59	8.07	090
63303		A	Removal of vertebral body	33.55	NA	NA	18.21	16.64	8.70	090
63304		A	Removal of vertebral body	33.85	NA	NA	20.51	18.60	8.77	090
63305		A	Removal of vertebral body	36.24	NA	NA	21.63	18.27	9.39	090
63306		A	Removal of vertebral body	35.55	NA	NA	21.30	19.56	9.21	090
63307		A	Removal of vertebral body	34.96	NA	NA	15.77	17.24	9.06	090
63308		A	Remove vertebral body add-on	5.24	NA	NA	2.40	2.30	1.13	ZZZ
63600		A	Remove spinal cord lesion	15.12	NA	NA	6.70	5.34	1.13	090
63610		A	Stimulation of spinal cord	8.72	13.78	22.32	1.66	1.82	0.50	000
63615		A	Remove lesion of spinal cord	17.32	NA	NA	8.50	8.95	4.48	090
63620		A	Srs, spinal lesion	15.60	NA	NA	9.73	7.70	0.54	090

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63621		A	Srs, spinal lesion, addl	4.00	NA	NA	1.78	1.63	0.20	ZZZ
63650		A	Implant neuroelectrodes	7.20	NA	NA	4.29	3.25	0.46	010
63655		A	Implant neuroelectrodes	11.56	NA	NA	9.09	8.09	2.60	090
63661		A	Remove spine eltrd perq aray	5.08	9.73	9.73	3.19	3.19	0.01	010
63662		A	Remove spine eltrd plate	11.00	NA	NA	6.94	6.94	1.10	090
63663		A	Revise spine eltrd perq aray	7.75	13.43	13.43	4.27	4.27	0.78	010
63664		A	Revise spine eltrd plate	11.52	NA	NA	7.15	7.15	1.15	090
63685		A	Insrt/redo spine n generator	6.05	NA	NA	4.13	3.51	0.79	010
63688		A	Revise/remove neuroreceiver	5.30	NA	NA	3.93	3.33	0.72	010
63700		A	Repair of spinal herniation	17.47	NA	NA	12.61	11.05	4.51	090
63702		A	Repair of spinal herniation	19.41	NA	NA	13.51	12.35	5.02	090
63704		A	Repair of spinal herniation	22.43	NA	NA	15.77	13.35	5.79	090
63706		A	Repair of spinal herniation	25.35	NA	NA	17.12	15.35	6.54	090
63707		A	Repair spinal fluid leakage	12.65	NA	NA	9.32	8.42	2.51	090
63709		A	Repair spinal fluid leakage	15.65	NA	NA	10.82	9.85	3.24	090
63710		A	Graft repair of spine defect	15.40	NA	NA	10.85	9.87	3.49	090
63740		A	Install spinal shunt	12.63	NA	NA	9.52	8.79	3.07	090
63741		A	Install spinal shunt	9.12	NA	NA	5.68	5.01	1.57	090
63744		A	Revision of spinal shunt	8.94	NA	NA	6.85	5.88	2.19	090
63746		A	Removal of spinal shunt	7.33	NA	NA	6.60	5.73	1.89	090
64400		A	N block inj, trigeminal	1.11	1.82	1.64	0.65	0.51	0.12	000
64402		A	N block inj, facial	1.25	1.76	1.55	0.72	0.58	0.13	000
64405		A	N block inj, occipital	1.32	1.61	1.35	0.73	0.57	0.18	000
64408		A	N block inj, vagus	1.41	1.78	1.62	0.97	0.85	0.12	000
64410		A	N block inj, phrenic	1.43	2.37	2.14	0.65	0.56	0.24	000
64412		A	N block inj, spinal accessor	1.18	2.83	2.43	0.78	0.62	0.13	000
64413		A	N block inj, cervical plexus	1.40	1.61	1.51	0.65	0.55	0.14	000
64415		A	N block inj, brachial plexus	1.48	1.73	1.77	0.41	0.37	0.09	000
64416		A	N block cont infuse, b plex	1.81	NA	NA	0.30	0.35	0.11	000
64417		A	N block inj, axillary	1.44	1.74	1.82	0.41	0.38	0.09	000
64418		A	N block inj, suprascapular	1.32	2.24	2.11	0.68	0.55	0.10	000
64420		A	N block inj, intercost, sng	1.18	3.02	2.90	0.63	0.50	0.09	000
64421		A	N block inj, intercost, mlt	1.68	4.50	4.35	0.78	0.62	0.14	000
64425		A	N block inj, ilio-ing/hypogi	1.75	1.72	1.50	0.78	0.62	0.14	000
64430		A	N block inj, pudendal	1.46	1.92	2.34	0.66	0.73	0.11	000
64435		A	N block inj, paracervical	1.45	1.91	2.10	0.70	0.64	0.18	000
64445		A	N block inj, sciatic, sng	1.48	1.92	1.91	0.63	0.55	0.12	000
64446		A	N blk inj, sciatic, cont inf	1.81	NA	NA	0.32	0.41	0.11	000
64447		A	N block inj fem, single	1.50	NA	NA	0.25	0.25	0.09	000

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64448		A	N block inj fem, cont inf	1.63	NA	NA	0.27	0.34	0.10	000
64449		A	N block inj, lumbar plexus	1.81	NA	NA	0.37	0.43	0.11	000
64450		A	N block, other peripheral	1.27	1.42	1.32	0.55	0.51	0.08	000
64455		A	N block inj, plantar digit	0.75	0.59	0.55	0.27	0.25	0.04	000
64479		A	Inj foramen epidural c/t	2.20	5.00	4.86	1.22	0.97	0.18	000
64480		A	Inj foramen epidural add-on	1.54	2.15	2.00	0.65	0.50	0.17	ZZZ
64483		A	Inj foramen epidural l/s	1.90	5.03	4.96	1.10	0.88	0.12	000
64484		A	Inj foramen epidural add-on	1.33	2.27	2.15	0.56	0.42	0.09	ZZZ
64490		A	Inj paravert f jnt c/t 1 lev	1.82	2.57	2.57	1.02	1.02	0.14	000
64491		A	Inj paravert f jnt c/t 2 lev	1.16	0.98	0.98	0.46	0.46	0.09	ZZZ
64492		A	Inj paravert f jnt c/t 3 lev	1.16	1.01	1.01	0.49	0.49	0.09	ZZZ
64493		A	Inj paravert f jnt l/s 1 lev	1.52	2.47	2.47	0.90	0.90	0.11	000
64494		A	Inj paravert f jnt l/s 2 lev	1.00	0.93	0.93	0.39	0.39	0.07	ZZZ
64495		A	Inj paravert f jnt l/s 3 lev	1.00	0.96	0.96	0.42	0.42	0.07	ZZZ
64505		A	N block, spenopalatine gangl	1.36	1.15	1.16	0.80	0.75	0.07	000
64508		A	N block, carotid sinus s/p	1.12	3.10	2.63	0.85	0.68	0.17	000
64510		A	N block, stellate ganglion	1.22	2.01	2.26	0.71	0.53	0.07	000
64517		A	N block inj, hypogas plxs	2.20	2.55	2.18	1.16	0.87	0.13	000
64520		A	N block, lumbar/thoracic	1.35	3.55	3.39	0.80	0.62	0.08	000
64530		A	N block inj, celiac pelus	1.58	3.41	3.29	0.89	0.73	0.11	000
64550		A	Apply neurostimulator	0.18	0.24	0.22	0.06	0.05	0.01	000
64553		A	Implant neuroelectrodes	2.36	3.06	2.81	1.79	1.65	0.27	010
64555		A	Implant neuroelectrodes	2.32	2.54	2.94	1.43	1.53	0.18	010
64560		A	Implant neuroelectrodes	2.41	2.61	2.84	1.51	1.56	0.12	010
64561		A	Implant neuroelectrodes	7.15	15.30	20.70	3.25	3.60	0.57	010
64565		A	Implant neuroelectrodes	1.81	2.84	2.57	1.52	1.26	0.17	010
64573		A	Implant neuroelectrodes	8.25	NA	NA	6.31	5.65	1.76	090
64575		A	Implant neuroelectrodes	4.42	NA	NA	3.20	2.63	0.32	090
64577		A	Implant neuroelectrodes	4.69	NA	NA	5.09	3.99	1.20	090
64580		A	Implant neuroelectrodes	4.19	NA	NA	3.35	3.16	0.64	090
64581		A	Implant neuroelectrodes	14.23	NA	NA	5.78	6.49	1.14	090
64585		A	Revise/remove neuroelectrode	2.11	4.02	5.83	1.59	1.84	0.20	010
64590		A	Insrt/redo pn/gastr stimul	2.45	4.02	5.17	1.65	1.97	0.21	010
64595		A	Revise/rmv pn/gastr stimul	1.78	4.22	5.94	1.44	1.69	0.15	010
64600		A	Injection treatment of nerve	3.49	6.72	6.62	2.28	1.88	0.39	010
64605		A	Injection treatment of nerve	5.65	13.53	9.62	4.06	2.89	0.32	010
64610		A	Injection treatment of nerve	7.20	10.84	9.69	4.36	4.04	1.55	010
64612		A	Destroy nerve, face muscle	2.01	2.11	1.93	1.83	1.50	0.47	010
64613		A	Destroy nerve, neck muscle	2.01	1.89	1.83	1.58	1.29	0.42	010

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64614		A	Destroy nerve, extrem musc	2.20	2.13	2.08	1.71	1.44	0.31	010
64620		A	Injection treatment of nerve	2.89	4.68	4.10	1.78	1.38	0.20	010
64622		A	Destr paravertebrl nerve l/s	3.05	5.80	5.30	2.06	1.54	0.18	010
64623		A	Destr paravertebral n add-on	0.99	2.31	2.11	0.41	0.28	0.06	ZZZ
64626		A	Destr paravertebrl nerve c/t	3.92	6.77	5.95	3.00	2.25	0.24	010
64627		A	Destr paravertebral n add-on	1.16	3.30	3.07	0.48	0.33	0.07	ZZZ
64630		A	Injection treatment of nerve	3.05	2.54	2.73	1.72	1.76	0.25	010
64632		A	N block inj, common digit	1.23	1.08	1.00	0.71	0.66	0.06	010
64640		A	Injection treatment of nerve	2.81	2.69	2.84	1.58	1.56	0.17	010
64650		A	Chemodenerv eccrine glands	0.70	1.12	1.01	0.35	0.29	0.09	000
64653		A	Chemodenerv eccrine glands	0.88	1.30	1.11	0.39	0.35	0.18	000
64680		A	Injection treatment of nerve	2.67	5.31	5.13	1.63	1.43	0.21	010
64681		A	Injection treatment of nerve	3.78	4.85	5.81	1.18	1.47	0.22	010
64702		A	Revise finger/toe nerve	6.26	NA	NA	6.30	5.35	0.74	090
64704		A	Revise hand/foot nerve	4.69	NA	NA	3.65	3.51	0.40	090
64708		A	Revise arm/leg nerve	6.36	NA	NA	5.98	5.33	0.81	090
64712		A	Revision of sciatic nerve	8.07	NA	NA	5.76	5.28	0.95	090
64713		A	Revision of arm nerve(s)	11.40	NA	NA	7.77	6.96	1.71	090
64714		A	Revise low back nerve(s)	10.55	NA	NA	7.18	5.66	1.24	090
64716		A	Revision of cranial nerve	6.99	NA	NA	6.67	6.03	0.80	090
64718		A	Revise ulnar nerve at elbow	7.26	NA	NA	7.40	6.63	1.03	090
64719		A	Revise ulnar nerve at wrist	4.97	NA	NA	4.95	4.54	0.67	090
64721		A	Carpal tunnel surgery	4.97	5.60	5.18	5.54	5.13	0.68	090
64722		A	Relieve pressure on nerve(s)	4.82	NA	NA	3.97	3.48	0.61	090
64726		A	Release foot/toe nerve	4.27	NA	NA	2.94	2.84	0.29	090
64727		A	Internal nerve revision	3.10	NA	NA	1.53	1.41	0.43	ZZZ
64732		A	Incision of brow nerve	4.89	NA	NA	5.34	4.43	1.24	090
64734		A	Incision of cheek nerve	5.55	NA	NA	6.04	4.74	0.50	090
64736		A	Incision of chin nerve	5.23	NA	NA	5.89	4.71	1.33	090
64738		A	Incision of jaw nerve	6.36	NA	NA	6.41	5.03	1.63	090
64740		A	Incision of tongue nerve	6.22	NA	NA	5.82	5.17	0.57	090
64742		A	Incision of facial nerve	6.85	NA	NA	5.98	4.91	0.62	090
64744		A	Incise nerve, back of head	5.72	NA	NA	5.72	4.38	1.47	090
64746		A	Incise diaphragm nerve	6.56	NA	NA	5.21	4.41	1.09	090
64752		A	Incision of vagus nerve	7.69	NA	NA	4.45	4.41	1.28	090
64755		A	Incision of stomach nerves	15.05	NA	NA	7.75	6.57	2.32	090
64760		A	Incision of vagus nerve	7.59	NA	NA	5.12	4.18	1.15	090
64761		A	Incision of pelvis nerve	7.04	NA	NA	4.62	4.14	0.71	090
64763		A	Incise hip/thigh nerve	7.56	NA	NA	5.03	5.45	1.15	090

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64766		A	Incise hip/thigh nerve	9.47	NA	NA	6.03	5.77	0.65	090
64771		A	Sever cranial nerve	8.15	NA	NA	6.24	6.02	0.74	090
64772		A	Incision of spinal nerve	7.84	NA	NA	6.39	5.76	1.28	090
64774		A	Remove skin nerve lesion	5.80	NA	NA	4.70	4.23	0.74	090
64776		A	Remove digit nerve lesion	5.60	NA	NA	4.37	3.97	0.60	090
64778		A	Digit nerve surgery add-on	3.11	NA	NA	1.53	1.39	0.44	ZZZ
64782		A	Remove limb nerve lesion	6.86	NA	NA	4.90	4.43	0.66	090
64783		A	Limb nerve surgery add-on	3.71	NA	NA	2.09	1.75	0.33	ZZZ
64784		A	Remove nerve lesion	10.62	NA	NA	7.86	6.96	1.45	090
64786		A	Remove sciatic nerve lesion	16.25	NA	NA	10.79	9.63	2.31	090
64787		A	Implant nerve end	4.29	NA	NA	1.94	1.87	0.49	ZZZ
64788		A	Remove skin nerve lesion	5.24	NA	NA	4.64	4.18	0.76	090
64790		A	Removal of nerve lesion	12.10	NA	NA	8.45	7.58	1.98	090
64792		A	Removal of nerve lesion	15.86	NA	NA	11.68	9.99	4.08	090
64795		A	Biopsy of nerve	3.01	NA	NA	1.79	1.60	0.59	000
64802		A	Remove sympathetic nerves	10.37	NA	NA	7.31	4.88	0.59	090
64804		A	Remove sympathetic nerves	15.91	NA	NA	4.15	5.42	0.90	090
64809		A	Remove sympathetic nerves	14.71	NA	NA	3.77	5.49	0.84	090
64818		A	Remove sympathetic nerves	11.34	NA	NA	5.44	4.89	1.49	090
64820		A	Remove sympathetic nerves	10.74	NA	NA	8.40	7.58	1.36	090
64821		A	Remove sympathetic nerves	9.33	NA	NA	7.84	7.28	1.31	090
64822		A	Remove sympathetic nerves	9.33	NA	NA	7.84	7.09	1.31	090
64823		A	Remove sympathetic nerves	10.94	NA	NA	8.63	7.65	1.54	090
64831		A	Repair of digit nerve	9.16	NA	NA	8.04	7.28	1.17	090
64832		A	Repair nerve add-on	5.65	NA	NA	3.01	2.72	0.72	ZZZ
64834		A	Repair of hand or foot nerve	10.81	NA	NA	7.96	7.23	1.33	090
64835		A	Repair of hand or foot nerve	11.73	NA	NA	8.57	7.80	1.66	090
64836		A	Repair of hand or foot nerve	11.73	NA	NA	8.57	7.82	1.66	090
64837		A	Repair nerve add-on	6.25	NA	NA	3.53	3.08	0.56	ZZZ
64840		A	Repair of leg nerve	14.02	NA	NA	5.55	7.59	0.77	090
64856		A	Repair/transpose nerve	15.07	NA	NA	10.59	9.52	2.04	090
64857		A	Repair arm/leg nerve	15.82	NA	NA	11.05	9.89	2.09	090
64858		A	Repair sciatic nerve	17.82	NA	NA	11.65	11.04	2.53	090
64859		A	Nerve surgery	4.25	NA	NA	2.08	1.99	0.60	ZZZ
64861		A	Repair of arm nerves	20.89	NA	NA	13.44	11.76	2.97	090
64862		A	Repair of low back nerves	21.09	NA	NA	14.12	11.12	5.46	090
64864		A	Repair of facial nerve	13.41	NA	NA	9.19	8.27	1.23	090
64865		A	Repair of facial nerve	16.09	NA	NA	13.34	12.60	1.49	090
64866		A	Fusion of facial/other nerve	16.83	NA	NA	13.70	12.72	1.56	090

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64868		A	Fusion of facial/other nerve	14.90	NA	NA	12.07	11.19	1.37	090
64870		A	Fusion of facial/other nerve	17.08	NA	NA	10.47	8.70	2.88	090
64872		A	Subsequent repair of nerve	1.99	NA	NA	1.12	0.99	0.18	ZZZ
64874		A	Repair & revise nerve add-on	2.98	NA	NA	1.39	1.34	0.27	ZZZ
64876		A	Repair nerve/shorten bone	3.37	NA	NA	1.98	1.49	0.48	ZZZ
64885		A	Nerve graft, head or neck	17.60	NA	NA	11.45	10.51	1.63	090
64886		A	Nerve graft, head or neck	20.82	NA	NA	13.89	12.50	1.94	090
64890		A	Nerve graft, hand or foot	16.24	NA	NA	10.78	10.08	2.31	090
64891		A	Nerve graft, hand or foot	17.35	NA	NA	11.42	10.39	2.47	090
64892		A	Nerve graft, arm or leg	15.74	NA	NA	10.54	9.74	2.24	090
64893		A	Nerve graft, arm or leg	16.87	NA	NA	11.19	10.03	2.40	090
64895		A	Nerve graft, hand or foot	20.39	NA	NA	12.91	11.48	2.90	090
64896		A	Nerve graft, hand or foot	21.96	NA	NA	15.44	13.23	5.68	090
64897		A	Nerve graft, arm or leg	19.38	NA	NA	12.42	11.35	2.75	090
64898		A	Nerve graft, arm or leg	20.97	NA	NA	13.48	12.49	2.98	090
64901		A	Nerve graft add-on	10.20	NA	NA	5.99	4.88	1.46	ZZZ
64902		A	Nerve graft add-on	11.81	NA	NA	6.94	5.56	1.70	ZZZ
64905		A	Nerve pedicle transfer	15.11	NA	NA	11.34	9.78	2.15	090
64907		A	Nerve pedicle transfer	20.03	NA	NA	9.19	10.96	1.00	090
64910		A	Nerve repair w/allograft	11.39	NA	NA	9.62	8.58	1.42	090
64911		A	Neurorraphy w/vein autograft	14.39	NA	NA	11.73	9.94	2.04	090
64999		C	Nervous system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
65091		A	Revise eye	7.26	NA	NA	8.83	7.78	1.01	090
65093		A	Revise eye with implant	7.04	NA	NA	8.83	7.90	0.98	090
65101		A	Removal of eye	8.30	NA	NA	10.38	9.12	1.15	090
65103		A	Remove eye/insert implant	8.84	NA	NA	10.66	9.34	1.23	090
65105		A	Remove eye/attach implant	9.93	NA	NA	11.65	10.14	1.39	090
65110		A	Removal of eye	15.70	NA	NA	15.38	13.28	1.44	090
65112		A	Remove eye/revise socket	18.51	NA	NA	17.93	15.40	1.70	090
65114		A	Remove eye/revise socket	19.65	NA	NA	18.60	15.85	1.81	090
65125		A	Revise ocular implant	3.27	7.88	7.49	4.14	3.59	0.45	090
65130		A	Insert ocular implant	8.42	NA	NA	10.14	8.83	1.17	090
65135		A	Insert ocular implant	8.60	NA	NA	10.25	8.95	1.19	090
65140		A	Attach ocular implant	9.46	NA	NA	11.06	9.66	0.86	090
65150		A	Revise ocular implant	6.43	NA	NA	8.17	7.31	0.32	090
65155		A	Reinsert ocular implant	10.10	NA	NA	11.44	9.99	1.41	090
65175		A	Removal of ocular implant	7.40	NA	NA	9.20	8.12	0.68	090
65205		A	Remove foreign body from eye	0.71	0.71	0.63	0.44	0.36	0.08	000
65210		A	Remove foreign body from eye	0.84	0.92	0.81	0.57	0.45	0.09	000

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65220		A	Remove foreign body from eye	0.71	0.75	0.66	0.39	0.32	0.08	000
65222		A	Remove foreign body from eye	0.93	1.00	0.88	0.60	0.48	0.11	000
65235		A	Remove foreign body from eye	9.01	NA	NA	9.22	7.65	0.87	090
65260		A	Remove foreign body from eye	12.54	NA	NA	12.13	10.14	0.62	090
65265		A	Remove foreign body from eye	14.34	NA	NA	13.49	11.21	2.18	090
65270		A	Repair of eye wound	1.95	4.55	4.34	1.70	1.41	0.19	010
65272		A	Repair of eye wound	4.62	7.87	7.14	4.44	3.65	0.22	090
65273		A	Repair of eye wound	5.16	NA	NA	4.70	3.89	0.25	090
65275		A	Repair of eye wound	6.29	8.32	7.00	5.68	4.52	0.61	090
65280		A	Repair of eye wound	9.10	NA	NA	8.26	6.79	1.26	090
65285		A	Repair of eye wound	14.71	NA	NA	12.18	9.93	1.85	090
65286		A	Repair of eye wound	6.63	10.91	9.97	6.18	5.08	0.64	090
65290		A	Repair of eye socket wound	6.53	NA	NA	6.14	5.11	0.90	090
65400		A	Removal of eye lesion	7.50	9.70	8.42	7.96	6.66	0.72	090
65410		A	Biopsy of cornea	1.47	2.10	1.91	1.23	1.01	0.23	000
65420		A	Removal of eye lesion	4.36	8.40	7.79	5.24	4.51	0.40	090
65426		A	Removal of eye lesion	6.05	10.17	9.28	6.23	5.24	0.59	090
65430		A	Corneal smear	1.47	1.46	1.26	1.21	1.01	0.15	000
65435		A	Curette/treat cornea	0.92	1.10	0.97	0.87	0.74	0.12	000
65436		A	Curette/treat cornea	4.82	5.10	4.31	4.74	3.95	0.60	090
65450		A	Treatment of corneal lesion	3.47	4.74	4.13	4.66	4.04	0.33	090
65600		A	Revision of cornea	4.20	5.73	5.01	4.59	3.82	0.41	090
65710		A	Corneal transplant	14.45	NA	NA	14.09	11.77	1.40	090
65730		A	Corneal transplant	16.35	NA	NA	15.36	12.76	1.59	090
65750		A	Corneal transplant	16.90	NA	NA	15.06	12.49	1.55	090
65755		A	Corneal transplant	16.79	NA	NA	15.00	12.44	1.64	090
65756		A	Corneal trnspl, endothelial	16.84	NA	NA	13.93	11.27	0.83	090
65757		C	Prep corneal endo allograft	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
65760		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65765		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65767		N	Corneal tissue transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65770		A	Revise cornea with implant	19.74	NA	NA	16.73	13.81	5.06	090
65771		N	Radial keratotomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65772		A	Correction of astigmatism	5.09	6.35	5.52	5.33	4.47	0.46	090
65775		A	Correction of astigmatism	6.91	NA	NA	7.23	6.13	0.34	090
65780		A	Ocular reconst, transplant	10.73	NA	NA	11.93	10.27	0.98	090
65781		A	Ocular reconst, transplant	18.14	NA	NA	16.38	13.73	0.89	090
65782		A	Ocular reconst, transplant	15.43	NA	NA	14.31	12.03	2.17	090
65800		A	Drainage of eye	1.91	1.90	1.66	1.49	1.22	0.19	000

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65805		A	Drainage of eye	1.91	2.23	1.99	1.50	1.23	0.24	000
65810		A	Drainage of eye	5.82	NA	NA	6.29	5.27	0.60	090
65815		A	Drainage of eye	6.00	9.89	9.03	6.25	5.23	0.74	090
65820		A	Relieve inner eye pressure	8.91	NA	NA	10.19	8.81	0.44	090
65850		A	Incision of eye	11.39	NA	NA	10.30	8.63	1.44	090
65855		A	Laser surgery of eye	3.99	4.63	4.06	3.69	3.10	0.44	010
65860		A	Incise inner eye adhesions	3.59	4.28	3.78	2.99	2.49	0.95	090
65865		A	Incise inner eye adhesions	5.77	NA	NA	6.31	5.46	0.28	090
65870		A	Incise inner eye adhesions	7.39	NA	NA	7.75	6.58	0.92	090
65875		A	Incise inner eye adhesions	7.81	NA	NA	8.33	7.05	0.75	090
65880		A	Incise inner eye adhesions	8.36	NA	NA	8.63	7.28	0.41	090
65900		A	Remove eye lesion	12.51	NA	NA	12.30	10.36	0.61	090
65920		A	Remove implant of eye	9.99	NA	NA	10.23	8.60	0.91	090
65930		A	Remove blood clot from eye	8.39	NA	NA	8.01	6.79	1.05	090
66020		A	Injection treatment of eye	1.64	2.98	2.75	1.73	1.47	0.08	010
66030		A	Injection treatment of eye	1.30	2.77	2.60	1.52	1.31	0.13	010
66130		A	Remove eye lesion	7.83	9.80	8.75	6.91	5.76	1.19	090
66150		A	Glaucoma surgery	10.53	NA	NA	11.86	10.02	0.51	090
66155		A	Glaucoma surgery	10.52	NA	NA	11.85	10.01	0.51	090
66160		A	Glaucoma surgery	12.39	NA	NA	12.96	10.87	0.60	090
66165		A	Glaucoma surgery	10.24	NA	NA	11.69	9.88	0.50	090
66170		A	Glaucoma surgery	15.02	NA	NA	15.76	13.19	1.35	090
66172		A	Incision of eye	18.86	NA	NA	19.96	16.66	1.71	090
66180		A	Implant eye shunt	16.30	NA	NA	13.91	11.44	1.51	090
66185		A	Revise eye shunt	9.58	NA	NA	9.68	8.07	1.19	090
66220		A	Repair eye lesion	9.21	NA	NA	9.85	8.09	0.89	090
66225		A	Repair/graft eye lesion	12.63	NA	NA	11.48	9.45	1.78	090
66250		A	Follow-up surgery of eye	7.10	11.56	10.55	7.21	6.00	0.98	090
66500		A	Incision of iris	3.83	NA	NA	5.11	4.49	0.19	090
66505		A	Incision of iris	4.22	NA	NA	5.58	4.89	0.21	090
66600		A	Remove iris and lesion	10.12	NA	NA	11.15	9.31	0.55	090
66605		A	Removal of iris	14.22	NA	NA	13.10	10.76	0.70	090
66625		A	Removal of iris	5.30	NA	NA	5.69	4.84	0.51	090
66630		A	Removal of iris	7.28	NA	NA	7.36	6.14	0.86	090
66635		A	Removal of iris	7.37	NA	NA	7.41	6.18	0.36	090
66680		A	Repair iris & ciliary body	6.39	NA	NA	6.84	5.74	0.96	090
66682		A	Repair iris & ciliary body	7.33	NA	NA	8.85	7.47	1.02	090
66700		A	Destruction, ciliary body	5.14	6.30	5.43	4.99	4.17	0.35	090
66710		A	Ciliary transsleral therapy	5.14	6.07	5.24	4.98	4.15	0.72	090

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66711		A	Ciliary endoscopic ablation	7.93	NA	NA	8.55	7.14	0.39	090
66720		A	Destruction, ciliary body	5.00	6.89	5.97	5.72	4.88	0.48	090
66740		A	Destruction, ciliary body	5.14	6.00	5.17	4.99	4.18	0.25	090
66761		A	Revision of iris	5.02	6.53	5.67	5.63	4.73	0.54	090
66762		A	Revision of iris	5.38	6.69	5.78	5.56	4.65	0.49	090
66770		A	Removal of inner eye lesion	6.13	7.32	6.28	6.30	5.25	0.30	090
66820		A	Incision, secondary cataract	4.01	NA	NA	5.88	5.31	0.48	090
66821		A	After cataract laser surgery	3.42	4.89	4.26	4.45	3.83	0.37	090
66825		A	Reposition intraocular lens	9.01	NA	NA	10.33	8.95	0.83	090
66830		A	Removal of lens lesion	9.47	NA	NA	8.94	7.41	0.46	090
66840		A	Removal of lens material	9.18	NA	NA	8.78	7.26	1.28	090
66850		A	Removal of lens material	10.55	NA	NA	9.91	8.21	1.02	090
66852		A	Removal of lens material	11.41	NA	NA	10.41	8.63	1.43	090
66920		A	Extraction of lens	10.13	NA	NA	9.36	7.75	0.50	090
66930		A	Extraction of lens	11.61	NA	NA	10.53	8.71	0.57	090
66940		A	Extraction of lens	10.37	NA	NA	9.81	8.13	1.23	090
66982		A	Cataract surgery, complex	15.02	NA	NA	12.38	10 21	1.69	090
66983		A	Cataract surg w/iol, 1 stage	10.43	NA	NA	8.73	7.26	0.58	090
66984		A	Cataract surg w/iol, 1 stage	10.52	NA	NA	9.16	7.64	1.17	090
66985		A	Insert lens prosthesis	9.98	NA	NA	9.85	8.17	0.91	090
66986		A	Exchange lens prosthesis	12.26	NA	NA	11.22	9.43	1.13	090
66990		A	Ophthalmic endoscope add-on	1.51	NA	NA	0.89	0.70	0.08	ZZZ
66999		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67005		A	Partial removal of eye fluid	5.89	NA	NA	6.21	5.22	0.89	090
67010		A	Partial removal of eye fluid	7.06	NA	NA	6.89	5.76	0.69	090
67015		A	Release of eye fluid	7.14	NA	NA	7.69	6.56	0.69	090
67025		A	Replace eye fluid	8.11	10.25	8.99	8.13	6.77	1.00	090
67027		A	Implant eye drug system	11.62	NA	NA	10.41	8.59	1.46	090
67028		A	Injection eye drug	2.52	2.85	2.52	1.86	1.51	0.27	000
67030		A	Incise inner eye strands	6.11	NA	NA	7.42	6.30	0.30	090
67031		A	Laser surgery, eye strands	4.47	5.40	4.66	4.68	3.92	0.41	090
67036		A	Removal of inner eye fluid	13.32	NA	NA	11.53	9.53	1.29	090
67039		A	Laser treatment of retina	16.74	NA	NA	15.17	12.61	2.10	090
67040		A	Laser treatment of retina	19.61	NA	NA	17.15	14.20	1.92	090
67041		A	Vit for macular pucker	19.25	NA	NA	15.25	12.26	1.90	090
67042		A	Vit for macular hole	22.38	NA	NA	17.10	13.66	2.21	090
67043		A	Vit for membrane dissect	23.24	NA	NA	18.26	14.63	2.93	090
67101		A	Repair detached retina	8.80	11.08	9.55	8.56	7.10	1.09	090
67105		A	Repair detached retina	8.53	9.85	8.42	8.08	6.69	0.83	090

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67107		A	Repair detached retina	16.71	NA	NA	14.76	12.13	2.10	090
67108		A	Repair detached retina	22.89	NA	NA	18.85	15.37	2.24	090
67110		A	Repair detached retina	10.25	11.86	10.24	9.72	8.05	0.93	090
67112		A	Rerepair detached retina	18.75	NA	NA	15.68	12.80	1.84	090
67113		A	Repair retinal detach, cplx	25.35	NA	NA	20.09	16.14	2.49	090
67115		A	Release encircling material	6.11	NA	NA	6.67	5.59	0.55	090
67120		A	Remove eye implant material	7.10	9.48	8.36	7.22	6.04	0.98	090
67121		A	Remove eye implant material	12.25	NA	NA	11.23	9.25	1.53	090
67141		A	Treatment of retina	6.15	7.19	6.14	6.36	5.31	0.76	090
67145		A	Treatment of retina	6.32	7.14	6.06	6.46	5.39	0.61	090
67208		A	Treatment of retinal lesion	7.65	7.74	6.50	7.26	6.01	0.38	090
67210		A	Treatment of retinal lesion	9.45	8.38	6.94	7.86	6.41	1.00	090
67218		A	Treatment of retinal lesion	20.36	NA	NA	15.73	12.78	1.01	090
67220		A	Treatment of choroid lesion	14.39	13.01	10.83	11.85	9.67	1.82	090
67221		R	Ocular photodynamic ther	3.45	3.87	3.54	2.19	1.76	0.34	000
67225		A	Eye photodynamic ther add-on	0.47	0.31	0.26	0.28	0.22	0.02	ZZZ
67227		A	Treatment of retinal lesion	7.53	8.10	6.87	7.19	5.96	0.37	090
67228		A	Treatment of retinal lesion	13.82	17.64	14.66	13.93	11.24	1.51	090
67229		A	Tr retinal les preterm inf	16.30	NA	NA	13.51	11.06	0.80	090
67250		A	Reinforce eye wall	9.61	NA	NA	10.35	8.93	1.15	090
67255		A	Reinforce/graft eye wall	10.17	NA	NA	11.29	9.75	1.43	090
67299		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67311		A	Revise eye muscle	7.77	NA	NA	7.62	6.37	0.92	090
67312		A	Revise two eye muscles	9.66	NA	NA	8.74	7.22	1.35	090
67314		A	Revise eye muscle	8.79	NA	NA	8.53	7.10	1.04	090
67316		A	Revise two eye muscles	10.93	NA	NA	9.71	8.01	1.53	090
67318		A	Revise eye muscle(s)	9.12	NA	NA	9.04	7.51	0.45	090
67320		A	Revise eye muscle(s) add-on	5.40	NA	NA	3.17	2.39	0.27	ZZZ
67331		A	Eye surgery follow-up add-on	5.13	NA	NA	2.99	2.25	0.62	ZZZ
67332		A	Rerevise eye muscles add-on	5.56	NA	NA	3.26	2.46	0.68	ZZZ
67334		A	Revise eye muscle w/suture	5.05	NA	NA	2.98	2.24	0.25	ZZZ
67335		A	Eye suture during surgery	2.49	NA	NA	1.45	1.14	0.30	ZZZ
67340		A	Revise eye muscle add-on	6.00	NA	NA	3.54	2.67	0.30	ZZZ
67343		A	Release eye tissue	8.47	NA	NA	8.29	6.94	1.18	090
67345		A	Destroy nerve of eye muscle	3.01	2.92	2.52	2.40	2.01	0.57	010
67346		A	Biopsy, eye muscle	2.87	NA	NA	2.35	1.94	0.44	000
67399		C	Eye muscle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67400		A	Explore/biopsy eye socket	11.20	NA	NA	12.52	10.89	1.47	090
67405		A	Explore/drain eye socket	9.20	NA	NA	10.92	9.62	0.83	090

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67412		A	Explore/treat eye socket	10.30	NA	NA	11.38	10.04	1.32	090
67413		A	Explore/treat eye socket	10.24	NA	NA	11.56	10.14	1.44	090
67414		A	Explr/decompress eye socket	17.94	NA	NA	16.27	13.43	1.66	090
67415		A	Aspiration, orbital contents	1.76	NA	NA	1.04	0.79	0.17	000
67420		A	Explore/treat eye socket	21.87	NA	NA	19.76	16.86	3.09	090
67430		A	Explore/treat eye socket	15.29	NA	NA	16.57	14.33	0.75	090
67440		A	Explore/drain eye socket	14.84	NA	NA	15.98	13.80	1.35	090
67445		A	Explr/decompress eye socket	19.12	NA	NA	17.02	14.29	2.71	090
67450		A	Explore/biopsy eye socket	15.41	NA	NA	16.64	14.36	1.41	090
67500		A	Inject/treat eye socket	1.44	0.84	0.69	0.68	0.50	0.08	000
67505		A	Inject/treat eye socket	1.27	1.05	0.84	0.87	0.63	0.18	000
67515		A	Inject/treat eye socket	1.40	1.12	0.86	0.95	0.69	0.18	000
67550		A	Insert eye socket implant	11.77	NA	NA	12.87	11.17	1.65	090
67560		A	Revise eye socket implant	12.18	NA	NA	13.03	11.27	1.10	090
67570		A	Decompress optic nerve	14.40	NA	NA	14.75	12.96	3.69	090
67599		C	Orbit surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67700		A	Drainage of eyelid abscess	1.40	4.98	4.88	1.55	1.32	0.15	010
67710		A	Incision of eyelid	1.07	4.25	4.22	1.39	1.22	0.15	010
67715		A	Incision of eyelid fold	1.27	4.39	4.31	1.50	1.30	0.18	010
67800		A	Remove eyelid lesion	1.41	1.80	1.59	1.27	1.06	0.17	010
67801		A	Remove eyelid lesions	1.91	2.22	1.93	1.57	1.29	0.27	010
67805		A	Remove eyelid lesions	2.27	2.85	2.49	2.00	1.67	0.32	010
67808		A	Remove eyelid lesion(s)	4.60	NA	NA	4.84	4.07	0.63	090
67810		A	Biopsy of eyelid	1.48	3.77	3.83	0.88	0.77	0.15	000
67820		A	Revise eyelashes	0.71	0.59	0.52	0.67	0.57	0.08	000
67825		A	Revise eyelashes	1.43	1.81	1.61	1.66	1.44	0.19	010
67830		A	Revise eyelashes	1.75	4.69	4.54	1.79	1.52	0.24	010
67835		A	Revise eyelashes	5.70	NA	NA	5.60	4.72	0.80	090
67840		A	Remove eyelid lesion	2.09	4.64	4.47	1.99	1.69	0.24	010
67850		A	Treat eyelid lesion	1.74	3.56	3.52	1.74	1.62	0.17	010
67875		A	Closure of eyelid by suture	1.35	2.85	2.73	1.17	0.98	0.18	000
67880		A	Revision of eyelid	4.60	6.87	6.18	4.84	4.07	0.57	090
67882		A	Revision of eyelid	6.02	8.18	7.26	6.11	5.13	0.83	090
67900		A	Repair brow defect	6.82	9.29	8.39	6.31	5.35	0.87	090
67901		A	Repair eyelid defect	7.59	11.26	9.11	7.24	6.01	1.06	090
67902		A	Repair eyelid defect	9.82	NA	NA	8.83	7.11	1.37	090
67903		A	Repair eyelid defect	6.51	8.46	7.84	5.98	5.15	0.90	090
67904		A	Repair eyelid defect	7.97	10.49	9.28	7.44	6.10	1.07	090
67906		A	Repair eyelid defect	6.93	NA	NA	6.23	5.21	0.34	090

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67908		A	Repair eyelid defect	5.30	7.15	6.34	5.59	4.89	0.73	090
67909		A	Revise eyelid defect	5.57	7.87	7.15	5.67	4.87	0.77	090
67911		A	Revise eyelid defect	7.50	NA	NA	7.01	5.71	0.99	090
67912		A	Correction eyelid w/implant	6.36	15.26	15.01	6.27	5.44	0.67	090
67914		A	Repair eyelid defect	3.75	5.90	5.47	3.65	3.11	0.49	090
67915		A	Repair eyelid defect	3.26	5.32	5.00	3.25	2.80	0.32	090
67916		A	Repair eyelid defect	5.48	8.01	7.28	5.60	4.79	0.68	090
67917		A	Repair eyelid defect	6.19	8.54	7.71	6.03	5.12	0.82	090
67921		A	Repair eyelid defect	3.47	5.73	5.32	3.49	2.96	0.49	090
67922		A	Repair eyelid defect	3.14	5.17	4.86	3.14	2.70	0.31	090
67923		A	Repair eyelid defect	6.05	8.25	7.41	5.95	5.03	0.80	090
67924		A	Repair eyelid defect	5.93	8.73	7.96	5.63	4.76	0.79	090
67930		A	Repair eyelid wound	3.65	5.47	5.04	2.65	2.18	0.51	010
67935		A	Repair eyelid wound	6.36	8.56	7.75	5.12	4.31	0.89	090
67938		A	Remove eyelid foreign body	1.38	4.46	4.36	1.57	1.36	0.15	010
67950		A	Revision of eyelid	5.99	8.38	7.66	5.91	5.09	0.79	090
67961		A	Revision of eyelid	5.86	8.56	7.80	5.84	5.00	0.78	090
67966		A	Revision of eyelid	8.97	10.54	9.16	8.03	6.54	1.21	090
67971		A	Reconstruction of eyelid	10.01	NA	NA	8.73	7.32	1.41	090
67973		A	Reconstruction of eyelid	13.13	NA	NA	11.06	9.25	1.86	090
67974		A	Reconstruction of eyelid	13.10	NA	NA	11.04	9.20	1.86	090
67975		A	Reconstruction of eyelid	9.35	NA	NA	8.37	7.03	1.31	090
67999		C	Revision of eyelid	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68020		A	Incise/drain eyelid lining	1.42	1.61	1.41	1.41	1.21	0.14	010
68040		A	Treatment of eyelid lesions	0.85	0.81	0.70	0.54	0.43	0.12	000
68100		A	Biopsy of eyelid lining	1.35	2.80	2.69	1.19	1.00	0.14	000
68110		A	Remove eyelid lining lesion	1.82	3.72	3.50	1.98	1.69	0.25	010
68115		A	Remove eyelid lining lesion	2.41	5.21	4.95	2.33	1.96	0.22	010
68130		A	Remove eyelid lining lesion	5.10	8.32	7.65	5.46	4.66	0.25	090
68135		A	Remove eyelid lining lesion	1.89	2.11	1.82	1.98	1.69	0.18	010
68200		A	Treat eyelid by injection	0.49	0.59	0.51	0.41	0.34	0.07	000
68320		A	Revise/graft eyelid lining	6.64	11.38	10.37	7.17	6.02	0.91	090
68325		A	Revise/graft eyelid lining	8.63	NA	NA	8.32	6.96	1.20	090
68326		A	Revise/graft eyelid lining	8.42	NA	NA	8.20	6.83	1.17	090
68328		A	Revise/graft eyelid lining	9.45	NA	NA	8.86	7.43	1.31	090
68330		A	Revise eyelid lining	5.78	9.30	8.47	6.06	5.08	0.80	090
68335		A	Revise/graft eyelid lining	8.46	NA	NA	8.24	6.85	1.17	090
68340		A	Separate eyelid adhesions	4.97	8.56	7.86	5.27	4.41	0.69	090
68360		A	Revise eyelid lining	5.17	8.08	7.34	5.38	4.52	0.72	090

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68362		A	Revise eyelid lining	8.61	NA	NA	8.28	6.89	1.19	090
68371		A	Harvest eye tissue, alograft	5.09	NA	NA	5.49	4.71	0.25	010
68399		C	Eyelid lining surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68400		A	Incise/drain tear gland	1.74	5.09	4.91	1.66	1.48	0.24	010
68420		A	Incise/drain tear sac	2.35	5.46	5.22	2.01	1.77	0.21	010
68440		A	Incise tear duct opening	0.99	1.57	1.52	1.50	1.31	0.13	010
68500		A	Removal of tear gland	12.77	NA	NA	12.37	10.30	2.13	090
68505		A	Partial removal, tear gland	12.69	NA	NA	12.32	10.46	1.78	090
68510		A	Biopsy of tear gland	4.60	6.55	6.10	3.09	2.43	0.65	000
68520		A	Removal of tear sac	8.78	NA	NA	8.87	7.54	0.79	090
68525		A	Biopsy of tear sac	4.42	NA	NA	2.60	2.03	0.63	000
68530		A	Clearance of tear duct	3.70	6.83	6.54	2.99	2.52	0.52	010
68540		A	Remove tear gland lesion	12.18	NA	NA	11.77	9.85	1.10	090
68550		A	Remove tear gland lesion	15.16	NA	NA	12.69	11.43	1.37	090
68700		A	Repair tear ducts	7.87	NA	NA	7.70	6.42	1.08	090
68705		A	Revise tear duct opening	2.11	3.74	3.50	2.16	1.83	0.30	010
68720		A	Create tear sac drain	9.96	NA	NA	9.49	8.03	1.19	090
68745		A	Create tear duct drain	9.90	NA	NA	9.67	8.15	1.39	090
68750		A	Create tear duct drain	10.10	NA	NA	10.13	8.55	1.41	090
68760		A	Close tear duct opening	1.78	3.18	2.98	1.95	1.67	0.25	010
68761		A	Close tear duct opening	1.41	2.26	2.08	1.62	1.40	0.15	010
68770		A	Close tear system fistula	8.29	NA	NA	7.94	6.02	1.15	090
68801		A	Dilate tear duct opening	1.00	2.11	1.92	1.72	1.54	0.12	010
68810		A	Probe nasolacrimal duct	2.15	3.85	3.49	2.61	2.34	0.28	010
68811		A	Probe nasolacrimal duct	2.45	NA	NA	2.82	2.43	0.34	010
68815		A	Probe nasolacrimal duct	3.30	7.64	7.21	3.31	2.82	0.41	010
68816		A	Probe nl duct w/balloon	3.06	14.53	13.35	3.36	2.84	0.43	010
68840		A	Explore/irrigate tear ducts	1.30	1.91	1.67	1.66	1.38	0.17	010
68850		A	Injection for tear sac x-ray	0.80	0.76	0.79	0.64	0.65	0.06	000
68899		C	Tear duct system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69000		A	Drain external ear lesion	1.50	3.21	3.00	1.60	1.44	0.14	010
69005		A	Drain external ear lesion	2.16	3.35	3.13	1.95	1.79	0.20	010
69020		A	Drain outer ear canal lesion	1.53	4.44	4.22	2.20	2.05	0.14	010
69090		N	Pierce earlobes	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69100		A	Biopsy of external ear	0.81	1.68	1.80	0.48	0.43	0.08	000
69105		A	Biopsy of external ear canal	0.85	2.73	2.64	0.83	0.77	0.08	000
69110		A	Remove external ear, partial	3.53	7.98	7.78	4.78	4.64	0.38	090
69120		A	Removal of external ear	4.14	NA	NA	6.27	5.86	0.42	090
69140		A	Remove ear canal lesion(s)	8.14	NA	NA	14.52	13.78	0.75	090

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69145		A	Remove ear canal lesion(s)	2.70	7.45	6.96	3.81	3.53	0.25	090
69150		A	Extensive ear canal surgery	13.61	NA	NA	13.62	12.73	1.40	090
69155		A	Extensive ear/neck surgery	23.35	NA	NA	20.71	19.07	2.15	090
69200		A	Clear outer ear canal	0.77	2.36	2.27	0.74	0.64	0.08	000
69205		A	Clear outer ear canal	1.21	NA	NA	1.43	1.33	0.11	010
69210		A	Remove impacted ear wax	0.61	0.71	0.63	0.26	0.21	0.06	000
69220		A	Clean out mastoid cavity	0.83	2.70	2.58	0.81	0.74	0.08	000
69222		A	Clean out mastoid cavity	1.45	4.19	4.04	2.13	2.02	0.13	010
69300		R	Revise external ear	6.69	11.25	9.67	5.88	5.28	0.62	YYY
69310		A	Rebuild outer ear canal	10.97	NA	NA	17.12	16.29	1.02	090
69320		A	Rebuild outer ear canal	17.18	NA	NA	22.70	21.51	1.59	090
69399		C	Outer ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69400		A	Inflate middle ear canal	0.83	2.94	2.74	0.81	0.73	0.08	000
69401		A	Inflate middle ear canal	0.63	1.59	1.46	0.66	0.62	0.06	000
69405		A	Catheterize middle ear canal	2.68	4.11	3.81	2.40	2.20	0.25	010
69420		A	Incision of eardrum	1.38	3.54	3.38	1.78	1.65	0.13	010
69421		A	Incision of eardrum	1.78	NA	NA	2.13	2.02	0.16	010
69424		A	Remove ventilating tube	0.85	2.44	2.36	0.79	0.72	0.08	000
69433		A	Create eardrum opening	1.57	3.57	3.38	1.84	1.70	0.14	010
69436		A	Create eardrum opening	2.01	NA	NA	2.22	2.10	0.18	010
69440		A	Exploration of middle ear	7.71	NA	NA	10.31	9.51	0.71	090
69450		A	Eardrum revision	5.69	NA	NA	8.51	7.88	0.52	090
69501		A	Mastoidectomy	9.21	NA	NA	10.05	9.20	0.84	090
69502		A	Mastoidectomy	12.56	NA	NA	12.87	11.86	1.21	090
69505		A	Remove mastoid structures	13.17	NA	NA	18.17	17.12	1.23	090
69511		A	Extensive mastoid surgery	13.70	NA	NA	18.46	17.41	1.26	090
69530		A	Extensive mastoid surgery	20.38	NA	NA	22.97	21.43	1.89	090
69535		A	Remove part of temporal bone	37.42	NA	NA	32.63	30.06	3.77	090
69540		A	Remove ear lesion	1.25	4.09	3.95	2.06	1.96	0.11	010
69550		A	Remove ear lesion	11.15	NA	NA	15.97	15.05	1.02	090
69552		A	Remove ear lesion	19.81	NA	NA	21.41	19.91	1.84	090
69554		A	Remove ear lesion	35.97	NA	NA	28.48	26.55	3.32	090
69601		A	Mastoid surgery revision	13.45	NA	NA	14.12	12.93	1.23	090
69602		A	Mastoid surgery revision	13.76	NA	NA	14.89	13.67	1.26	090
69603		A	Mastoid surgery revision	14.20	NA	NA	18.71	17.74	1.30	090
69604		A	Mastoid surgery revision	14.20	NA	NA	15.10	14.03	1.30	090
69605		A	Mastoid surgery revision	18.69	NA	NA	22.16	20.75	1.74	090
69610		A	Repair of eardrum	4.47	5.59	5.31	3.27	2.99	0.41	010
69620		A	Repair of eardrum	6.03	11.83	11.33	6.76	6.29	0.55	090

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69631		A	Repair eardrum structures	10.05	NA	NA	13.09	12.09	0.92	090
69632		A	Rebuild eardrum structures	12.96	NA	NA	15.32	14.15	1.19	090
69633		A	Rebuild eardrum structures	12.31	NA	NA	15.01	13.84	1.14	090
69635		A	Repair eardrum structures	13.51	NA	NA	18.14	17.16	1.25	090
69636		A	Rebuild eardrum structures	15.43	NA	NA	20.59	19.36	1.42	090
69637		A	Rebuild eardrum structures	15.32	NA	NA	20.54	19.32	1.45	090
69641		A	Revise middle ear & mastoid	12.89	NA	NA	14.45	13.32	1.20	090
69642		A	Revise middle ear & mastoid	17.06	NA	NA	18.13	16.70	1.58	090
69643		A	Revise middle ear & mastoid	15.59	NA	NA	16.57	15.25	1.45	090
69644		A	Revise middle ear & mastoid	17.23	NA	NA	21.41	20.14	1.60	090
69645		A	Revise middle ear & mastoid	16.71	NA	NA	21.16	19.91	1.56	090
69646		A	Revise middle ear & mastoid	18.37	NA	NA	21.98	20.54	1.71	090
69650		A	Release middle ear bone	9.80	NA	NA	11.32	10.24	0.90	090
69660		A	Revise middle ear bone	12.03	NA	NA	12.36	11.38	1.11	090
69661		A	Revise middle ear bone	15.92	NA	NA	15.86	14.65	1.45	090
69662		A	Revise middle ear bone	15.60	NA	NA	14.88	13.68	1.46	090
69666		A	Repair middle ear structures	9.89	NA	NA	11.30	10.38	0.91	090
69667		A	Repair middle ear structures	9.90	NA	NA	11.30	10.43	0.91	090
69670		A	Remove mastoid air cells	11.73	NA	NA	13.09	12.00	1.08	090
69676		A	Remove middle ear nerve	9.69	NA	NA	12.11	11.24	0.89	090
69700		A	Close mastoid fistula	8.37	NA	NA	9.64	9.03	0.77	090
69710		N	Implant/replace hearing aid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69711		A	Remove/repair hearing aid	10.62	NA	NA	12.05	11.19	0.97	090
69714		A	Implant temple bone w/stimul	14.45	NA	NA	13.92	12.76	1.33	090
69715		A	Temple bne implnt w/stimulat	18.96	NA	NA	16.26	14.80	1.76	090
69717		A	Temple bone implant revision	15.43	NA	NA	14.43	13.44	1.42	090
69718		A	Revise temple bone implant	19.21	NA	NA	16.38	14.94	1.78	090
69720		A	Release facial nerve	14.71	NA	NA	16.18	14.89	1.35	090
69725		A	Release facial nerve	27.64	NA	NA	22.29	20.10	2.56	090
69740		A	Repair facial nerve	16.27	NA	NA	14.63	13.36	1.51	090
69745		A	Repair facial nerve	17.02	NA	NA	15.82	14.58	1.57	090
69799		C	Middle ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69801		A	Incise inner ear	8.70	NA	NA	10.97	10.13	0.80	090
69802		A	Incise inner ear	13.50	NA	NA	13.94	12.78	1.24	090
69805		A	Explore inner ear	14.71	NA	NA	13.20	11.95	1.35	090
69806		A	Explore inner ear	12.63	NA	NA	12.31	11.27	1.17	090
69820		A	Establish inner ear window	10.52	NA	NA	12.01	11.18	0.96	090
69840		A	Revise inner ear window	10.44	NA	NA	14.29	12.72	0.52	090
69905		A	Remove inner ear	11.26	NA	NA	12.86	11.91	1.03	090

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69910		A	Remove inner ear & mastoid	13.91	NA	NA	13.08	11.93	1.28	090
69915		A	Incise inner ear nerve	22.77	NA	NA	14.30	15.29	2.14	090
69930		A	Implant cochlear device	17.73	NA	NA	14.67	13.57	1.65	090
69949		C	Inner ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69950		A	Incise inner ear nerve	27.63	NA	NA	19.85	18.24	2.56	090
69955		A	Release facial nerve	29.42	NA	NA	23.16	20.93	2.72	090
69960		A	Release inner ear canal	29.42	NA	NA	21.82	19.56	2.72	090
69970		A	Remove inner ear lesion	32.41	NA	NA	24.59	22.23	3.00	090
69979		C	Temporal bone surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69990		R	Microsurgery add-on	3.46	NA	NA	1.61	1.52	0.83	ZZZ
70010		A	Contrast x-ray of brain	1.19	2.43	3.12	NA	NA	0.15	XXX
70010	TC	A	Contrast x-ray of brain	0.00	2.07	2.70	NA	NA	0.01	XXX
70010	26	A	Contrast x-ray of brain	1.19	0.36	0.42	0.36	0.42	0.14	XXX
70015		A	Contrast x-ray of brain	1.19	2.59	2.63	NA	NA	0.06	XXX
70015	TC	A	Contrast x-ray of brain	0.00	2.21	2.19	NA	NA	0.01	XXX
70015	26	A	Contrast x-ray of brain	1.19	0.38	0.44	0.38	0.44	0.05	XXX
70030		A	X-ray eye for foreign body	0.17	0.53	0.57	NA	NA	0.02	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.48	0.51	NA	NA	0.01	XXX
70030	26	A	X-ray eye for foreign body	0.17	0.05	0.06	0.05	0.06	0.01	XXX
70100		A	X-ray exam of jaw	0.18	0.61	0.63	NA	NA	0.02	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.55	0.57	NA	NA	0.01	XXX
70100	26	A	X-ray exam of jaw	0.18	0.06	0.06	0.06	0.06	0.01	XXX
70110		A	X-ray exam of jaw	0.25	0.72	0.78	NA	NA	0.02	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.64	0.69	NA	NA	0.01	XXX
70110	26	A	X-ray exam of jaw	0.25	0.08	0.09	0.08	0.09	0.01	XXX
70120		A	X-ray exam of mastoids	0.18	0.75	0.70	NA	NA	0.02	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.68	0.64	NA	NA	0.01	XXX
70120	26	A	X-ray exam of mastoids	0.18	0.07	0.06	0.07	0.06	0.01	XXX
70130		A	X-ray exam of mastoids	0.34	1.07	1.10	NA	NA	0.02	XXX
70130	TC	A	X-ray exam of mastoids	0.00	0.96	0.98	NA	NA	0.01	XXX
70130	26	A	X-ray exam of mastoids	0.34	0.11	0.12	0.11	0.12	0.01	XXX
70134		A	X-ray exam of middle ear	0.34	0.79	0.87	NA	NA	0.02	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.69	0.75	NA	NA	0.01	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.10	0.12	0.10	0.12	0.01	XXX
70140		A	X-ray exam of facial bones	0.19	0.54	0.58	NA	NA	0.02	XXX
70140	TC	A	X-ray exam of facial bones	0.00	0.47	0.52	NA	NA	0.01	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.07	0.06	0.07	0.06	0.01	XXX
70150		A	X-ray exam of facial bones	0.26	0.79	0.85	NA	NA	0.02	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.70	0.76	NA	NA	0.01	XXX

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70150	26	A	X-ray exam of facial bones	0.26	0.09	0.09	0.09	0.09	0.01	XXX
70160		A	X-ray exam of nasal bones	0.17	0.63	0.67	NA	NA	0.02	XXX
70160	TC	A	X-ray exam of nasal bones	0.00	0.58	0.61	NA	NA	0.01	XXX
70160	26	A	X-ray exam of nasal bones	0.17	0.05	0.06	0.05	0.06	0.01	XXX
70170		C	X-ray exam of tear duct	0.00	0.00	0.00	NA	NA	0.00	XXX
70170	TC	C	X-ray exam of tear duct	0.00	0.00	0.00	NA	NA	0.00	XXX
70170	26	A	X-ray exam of tear duct	0.30	0.09	0.11	0.09	0.11	0.02	XXX
70190		A	X-ray exam of eye sockets	0.21	0.66	0.71	NA	NA	0.02	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.59	0.64	NA	NA	0.01	XXX
70190	26	A	X-ray exam of eye sockets	0.21	0.07	0.07	0.07	0.07	0.01	XXX
70200		A	X-ray exam of eye sockets	0.28	0.79	0.87	NA	NA	0.02	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.70	0.77	NA	NA	0.01	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.09	0.10	0.09	0.10	0.01	XXX
70210		A	X-ray exam of sinuses	0.17	0.59	0.61	NA	NA	0.02	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.53	0.55	NA	NA	0.01	XXX
70210	26	A	X-ray exam of sinuses	0.17	0.06	0.06	0.06	0.06	0.01	XXX
70220		A	X-ray exam of sinuses	0.25	0.71	0.76	NA	NA	0.02	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.62	0.68	NA	NA	0.01	XXX
70220	26	A	X-ray exam of sinuses	0.25	0.09	0.08	0.09	0.08	0.01	XXX
70240		A	X-ray exam, pituitary saddle	0.19	0.52	0.58	NA	NA	0.02	XXX
70240	TC	A	X-ray exam, pituitary saddle	0.00	0.46	0.51	NA	NA	0.01	XXX
70240	26	A	X-ray exam, pituitary saddle	0.19	0.06	0.07	0.06	0.07	0.01	XXX
70250		A	X-ray exam of skull	0.24	0.68	0.70	NA	NA	0.02	XXX
70250	TC	A	X-ray exam of skull	0.00	0.59	0.62	NA	NA	0.01	XXX
70250	26	A	X-ray exam of skull	0.24	0.09	0.08	0.09	0.08	0.01	XXX
70260		A	X-ray exam of skull	0.34	0.83	0.89	NA	NA	0.02	XXX
70260	TC	A	X-ray exam of skull	0.00	0.71	0.78	NA	NA	0.01	XXX
70260	26	A	X-ray exam of skull	0.34	0.12	0.11	0.12	0.11	0.01	XXX
70300		A	X-ray exam of teeth	0.10	0.25	0.26	NA	NA	0.02	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.20	0.22	NA	NA	0.01	XXX
70300	26	A	X-ray exam of teeth	0.10	0.05	0.04	0.05	0.04	0.01	XXX
70310		A	X-ray exam of teeth	0.16	0.83	0.77	NA	NA	0.02	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.74	0.70	NA	NA	0.01	XXX
70310	26	A	X-ray exam of teeth	0.16	0.09	0.07	0.09	0.07	0.01	XXX
70320		A	Full mouth x-ray of teeth	0.22	1.07	1.05	NA	NA	0.02	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	0.96	0.96	NA	NA	0.01	XXX
70320	26	A	Full mouth x-ray of teeth	0.22	0.11	0.09	0.11	0.09	0.01	XXX
70328		A	X-ray exam of jaw joint	0.18	0.59	0.61	NA	NA	0.02	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.53	0.55	NA	NA	0.01	XXX

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70328	26	A	X-ray exam of jaw joint	0.18	0.06	0.06	0.06	0.06	0.01	XXX
70330		A	X-ray exam of jaw joints	0.24	0.95	0.99	NA	NA	0.02	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	0.86	0.90	NA	NA	0.01	XXX
70330	26	A	X-ray exam of jaw joints	0.24	0.09	0.09	0.09	0.09	0.01	XXX
70332		A	X-ray exam of jaw joint	0.54	1.57	1.66	NA	NA	0.03	XXX
70332	TC	A	X-ray exam of jaw joint	0.00	1.33	1.46	NA	NA	0.01	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.24	0.20	0.24	0.20	0.02	XXX
70336		A	Magnetic image, jaw joint	1.48	6.32	10.76	NA	NA	0.07	XXX
70336	TC	A	Magnetic image, jaw joint	0.00	5.87	10.23	NA	NA	0.01	XXX
70336	26	A	Magnetic image, jaw joint	1.48	0.45	0.53	0.45	0.53	0.06	XXX
70350		A	X-ray head for orthodontia	0.17	0.37	0.37	NA	NA	0.02	XXX
70350	TC	A	X-ray head for orthodontia	0.00	0.27	0.30	NA	NA	0.01	XXX
70350	26	A	X-ray head for orthodontia	0.17	0.10	0.07	0.10	0.07	0.01	XXX
70355		A	Panoramic x-ray of jaws	0.20	0.32	0.37	NA	NA	0.02	XXX
70355	TC	A	Panoramic x-ray of jaws	0.00	0.22	0.29	NA	NA	0.01	XXX
70355	26	A	Panoramic x-ray of jaws	0.20	0.10	0.08	0.10	0.08	0.01	XXX
70360		A	X-ray exam of neck	0.17	0.50	0.54	NA	NA	0.02	XXX
70360	TC	A	X-ray exam of neck	0.00	0.45	0.48	NA	NA	0.01	XXX
70360	26	A	X-ray exam of neck	0.17	0.05	0.06	0.05	0.06	0.01	XXX
70370		A	Throat x-ray & fluoroscopy	0.32	1.76	1.69	NA	NA	0.02	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	1.65	1.58	NA	NA	0.01	XXX
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.11	0.11	0.11	0.11	0.01	XXX
70371		A	Speech evaluation, complex	0.84	1.48	1.67	NA	NA	0.02	XXX
70371	TC	A	Speech evaluation, complex	0.00	1.19	1.39	NA	NA	0.01	XXX
70371	26	A	Speech evaluation, complex	0.84	0.29	0.28	0.29	0.28	0.01	XXX
70373		A	Contrast x-ray of larynx	0.44	1.65	1.67	NA	NA	0.02	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.49	1.54	NA	NA	0.01	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.16	0.13	0.16	0.13	0.01	XXX
70380		A	X-ray exam of salivary gland	0.17	0.83	0.81	NA	NA	0.02	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.74	0.74	NA	NA	0.01	XXX
70380	26	A	X-ray exam of salivary gland	0.17	0.09	0.07	0.09	0.07	0.01	XXX
70390		A	X-ray exam of salivary duct	0.38	2.06	2.22	NA	NA	0.03	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	1.94	2.08	NA	NA	0.01	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.12	0.14	0.12	0.14	0.02	XXX
70450		A	Ct head/brain w/o dye	0.85	2.74	4.45	NA	NA	0.04	XXX
70450	TC	A	Ct head/brain w/o dye	0.00	2.49	4.14	NA	NA	0.01	XXX
70450	26	A	Ct head/brain w/o dye	0.85	0.25	0.31	0.25	0.31	0.03	XXX
70460		A	Ct head/brain w/dye	1.13	3.64	5.77	NA	NA	0.05	XXX
70460	TC	A	Ct head/brain w/dye	0.00	3.29	5.36	NA	NA	0.01	XXX

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70460	26	A	Ct head/brain w/dye	1.13	0.35	0.41	0.35	0.41	0.04	XXX
70470		A	Ct head/brain w/o & w/dye	1.27	4.42	7.06	NA	NA	0.06	XXX
70470	TC	A	Ct head/brain w/o & w/dye	0.00	4.03	6.60	NA	NA	0.01	XXX
70470	26	A	Ct head/brain w/o & w/dye	1.27	0.39	0.46	0.39	0.46	0.05	XXX
70480		A	Ct orbit/ear/fossa w/o dye	1.28	4.76	7.01	NA	NA	0.06	XXX
70480	TC	A	Ct orbit/ear/fossa w/o dye	0.00	4.36	6.55	NA	NA	0.01	XXX
70480	26	A	Ct orbit/ear/fossa w/o dye	1.28	0.40	0.46	0.40	0.46	0.05	XXX
70481		A	Ct orbit/ear/fossa w/dye	1.38	5.57	8.24	NA	NA	0.07	XXX
70481	TC	A	Ct orbit/ear/fossa w/dye	0.00	5.15	7.74	NA	NA	0.01	XXX
70481	26	A	Ct orbit/ear/fossa w/dye	1.38	0.42	0.50	0.42	0.50	0.06	XXX
70482		A	Ct orbit/ear/fossa w/o&w/dye	1.45	6.29	9.51	NA	NA	0.07	XXX
70482	TC	A	Ct orbit/ear/fossa w/o&w/dye	0.00	5.85	8.99	NA	NA	0.01	XXX
70482	26	A	Ct orbit/ear/fossa w/o&w/dye	1.45	0.44	0.52	0.44	0.52	0.06	XXX
70486		A	Ct maxillofacial w/o dye	1.14	3.85	5.81	NA	NA	0.05	XXX
70486	TC	A	Ct maxillofacial w/o dye	0.00	3.49	5.40	NA	NA	0.01	XXX
70486	26	A	Ct maxillofacial w/o dye	1.14	0.36	0.41	0.36	0.41	0.04	XXX
70487		A	Ct maxillofacial w/dye	1.30	4.66	7.09	NA	NA	0.06	XXX
70487	TC	A	Ct maxillofacial w/dye	0.00	4.27	6.62	NA	NA	0.01	XXX
70487	26	A	Ct maxillofacial w/dye	1.30	0.39	0.47	0.39	0.47	0.05	XXX
70488		A	Ct maxillofacial w/o & w/dye	1.42	5.73	8.78	NA	NA	0.07	XXX
70488	TC	A	Ct maxillofacial w/o & w/dye	0.00	5.30	8.27	NA	NA	0.01	XXX
70488	26	A	Ct maxillofacial w/o & w/dye	1.42	0.43	0.51	0.43	0.51	0.06	XXX
70490		A	Ct soft tissue neck w/o dye	1.28	3.63	5.59	NA	NA	0.06	XXX
70490	TC	A	Ct soft tissue neck w/o dye	0.00	3.24	5.12	NA	NA	0.01	XXX
70490	26	A	Ct soft tissue neck w/o dye	1.28	0.39	0.47	0.39	0.47	0.05	XXX
70491		A	Ct soft tissue neck w/dye	1.38	4.50	6.87	NA	NA	0.06	XXX
70491	TC	A	Ct soft tissue neck w/dye	0.00	4.07	6.37	NA	NA	0.01	XXX
70491	26	A	Ct soft tissue neck w/dye	1.38	0.43	0.50	0.43	0.50	0.05	XXX
70492		A	Ct sft tsue nck w/o & w/dye	1.45	5.52	8.54	NA	NA	0.07	XXX
70492	TC	A	Ct sft tsue nck w/o & w/dye	0.00	5.08	8.02	NA	NA	0.01	XXX
70492	26	A	Ct sft tsue nck w/o & w/dye	1.45	0.44	0.52	0.44	0.52	0.06	XXX
70496		A	Ct angiography, head	1.75	15.01	15.63	NA	NA	0.08	XXX
70496	TC	A	Ct angiography, head	0.00	14.48	14.99	NA	NA	0.01	XXX
70496	26	A	Ct angiography, head	1.75	0.53	0.64	0.53	0.64	0.07	XXX
70498		A	Ct angiography, neck	1.75	14.91	15.67	NA	NA	0.08	XXX
70498	TC	A	Ct angiography, neck	0.00	14.38	15.02	NA	NA	0.01	XXX
70498	26	A	Ct angiography, neck	1.75	0.53	0.65	0.53	0.65	0.07	XXX
70540		A	Mri orbit/face/neck w/o dye	1.35	7.28	12.10	NA	NA	0.07	XXX
70540	TC	A	Mri orbit/face/neck w/o dye	0.00	6.87	11.62	NA	NA	0.01	XXX

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70540	26	A	Mri orbit/face/neck w/o dye	1.35	0.41	0.48	0.41	0.48	0.06	XXX
70542		A	Mri orbit/face/neck w/dye	1.62	8.09	13.32	NA	NA	0.08	XXX
70542	TC	A	Mri orbit/face/neck w/dye	0.00	7.60	12.75	NA	NA	0.01	XXX
70542	26	A	Mri orbit/face/neck w/dye	1.62	0.49	0.57	0.49	0.57	0.07	XXX
70543		A	Mri orbt/fac/nck w/o & w/dye	2.15	9.87	18.00	NA	NA	0.11	XXX
70543	TC	A	Mri orbt/fac/nck w/o & w/dye	0.00	9.22	17.24	NA	NA	0.02	XXX
70543	26	A	Mri orbt/fac/nck w/o & w/dye	2.15	0.65	0.76	0.65	0.76	0.09	XXX
70544		A	Mr angiography head w/o dye	1.20	13.98	14.73	NA	NA	0.06	XXX
70544	TC	A	Mr angiography head w/o dye	0.00	13.62	14.30	NA	NA	0.01	XXX
70544	26	A	Mr angiography head w/o dye	1.20	0.36	0.43	0.36	0.43	0.05	XXX
70545		A	Mr angiography head w/dye	1.20	13.83	14.64	NA	NA	0.06	XXX
70545	TC	A	Mr angiography head w/dye	0.00	13.47	14.21	NA	NA	0.01	XXX
70545	26	A	Mr angiography head w/dye	1.20	0.36	0.43	0.36	0.43	0.05	XXX
70546		A	Mr angiograph head w/o&w/dye	1.80	21.23	23.37	NA	NA	0.10	XXX
70546	TC	A	Mr angiograph head w/o&w/dye	0.00	20.68	22.73	NA	NA	0.02	XXX
70546	26	A	Mr angiograph head w/o&w/dye	1.80	0.55	0.64	0.55	0.64	0.08	XXX
70547		A	Mr angiography neck w/o dye	1.20	13.94	14.69	NA	NA	0.06	XXX
70547	TC	A	Mr angiography neck w/o dye	0.00	13.57	14.26	NA	NA	0.01	XXX
70547	26	A	Mr angiography neck w/o dye	1.20	0.37	0.43	0.37	0.43	0.05	XXX
70548		A	Mr angiography neck w/dye	1.20	14.80	15.39	NA	NA	0.06	XXX
70548	TC	A	Mr angiography neck w/dye	0.00	14.44	14.96	NA	NA	0.01	XXX
70548	26	A	Mr angiography neck w/dye	1.20	0.36	0.43	0.36	0.43	0.05	XXX
70549		A	Mr angiograph neck w/o&w/dye	1.80	21.17	23.37	NA	NA	0.09	XXX
70549	TC	A	Mr angiograph neck w/o&w/dye	0.00	20.63	22.73	NA	NA	0.02	XXX
70549	26	A	Mr angiograph neck w/o&w/dye	1.80	0.54	0.64	0.54	0.64	0.07	XXX
70551		A	Mri brain w/o dye	1.48	7.59	12.35	NA	NA	0.07	XXX
70551	TC	A	Mri brain w/o dye	0.00	7.14	11.82	NA	NA	0.01	XXX
70551	26	A	Mri brain w/o dye	1.48	0.45	0.53	0.45	0.53	0.06	XXX
70552		A	Mri brain w/dye	1.78	8.43	13.67	NA	NA	0.09	XXX
70552	TC	A	Mri brain w/dye	0.00	7.89	13.03	NA	NA	0.01	XXX
70552	26	A	Mri brain w/dye	1.78	0.54	0.64	0.54	0.64	0.08	XXX
70553		A	Mri brain w/o & w/dye	2.36	9.71	17.62	NA	NA	0.12	XXX
70553	TC	A	Mri brain w/o & w/dye	0.00	8.99	16.77	NA	NA	0.02	XXX
70553	26	A	Mri brain w/o & w/dye	2.36	0.72	0.85	0.72	0.85	0.10	XXX

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70554		A	Fmri brain by tech	2.11	9.00	13.07	NA	NA	0.11	XXX
70554	TC	A	Fmri brain by tech	0.00	8.33	12.29	NA	NA	0.02	XXX
70554	26	A	Fmri brain by tech	2.11	0.67	0.78	0.67	0.78	0.09	XXX
70555		C	Fmri brain by phys/psych	0.00	0.00	0.00	NA	NA	0.00	XXX
70555	TC	C	Fmri brain by phys/psych	0.00	0.00	0.00	NA	NA	0.00	XXX
70555	26	A	Fmri brain by phys/psych	2.54	0.76	0.94	0.76	0.94	0.17	XXX
70557		C	Mri brain w/o dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70557	TC	C	Mri brain w/o dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70557	26	A	Mri brain w/o dye	2.90	1.35	1.20	1.35	1.20	0.75	XXX
70558		C	Mri brain w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70558	TC	C	Mri brain w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70558	26	A	Mri brain w/dye	3.20	0.97	1.15	0.97	1.15	0.21	XXX
70559		C	Mri brain w/o & w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70559	TC	C	Mri brain w/o & w/dye	0.00	0.00	0.00	NA	NA	0.00	XXX
70559	26	A	Mri brain w/o & w/dye	3.20	1.08	1.23	1.08	1.23	0.21	XXX
71010		A	Chest x-ray	0.18	0.39	0.44	NA	NA	0.02	XXX
71010	TC	A	Chest x-ray	0.00	0.33	0.38	NA	NA	0.01	XXX
71010	26	A	Chest x-ray	0.18	0.06	0.06	0.06	0.06	0.01	XXX
71015		A	Chest x-ray	0.21	0.54	0.57	NA	NA	0.02	XXX
71015	TC	A	Chest x-ray	0.00	0.47	0.50	NA	NA	0.01	XXX
71015	26	A	Chest x-ray	0.21	0.07	0.07	0.07	0.07	0.01	XXX
71020		A	Chest x-ray	0.22	0.52	0.60	NA	NA	0.02	XXX
71020	TC	A	Chest x-ray	0.00	0.45	0.52	NA	NA	0.01	XXX
71020	26	A	Chest x-ray	0.22	0.07	0.08	0.07	0.08	0.01	XXX
71021		A	Chest x-ray	0.27	0.66	0.72	NA	NA	0.02	XXX
71021	TC	A	Chest x-ray	0.00	0.57	0.63	NA	NA	0.01	XXX
71021	26	A	Chest x-ray	0.27	0.09	0.09	0.09	0.09	0.01	XXX
71022		A	Chest x-ray	0.31	0.84	0.90	NA	NA	0.02	XXX
71022	TC	A	Chest x-ray	0.00	0.74	0.79	NA	NA	0.01	XXX
71022	26	A	Chest x-ray	0.31	0.10	0.11	0.10	0.11	0.01	XXX
71023		A	Chest x-ray and fluoroscopy	0.38	1.37	1.41	NA	NA	0.02	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	1.24	1.26	NA	NA	0.01	XXX
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.13	0.15	0.13	0.15	0.01	XXX
71030		A	Chest x-ray	0.31	0.81	0.90	NA	NA	0.02	XXX
71030	TC	A	Chest x-ray	0.00	0.71	0.79	NA	NA	0.01	XXX
71030	26	A	Chest x-ray	0.31	0.10	0.11	0.10	0.11	0.01	XXX
71034		A	Chest x-ray and fluoroscopy	0.46	1.63	1.91	NA	NA	0.02	XXX
71034	TC	A	Chest x-ray and fluoroscopy	0.00	1.48	1.71	NA	NA	0.01	XXX
71034	26	A	Chest x-ray and fluoroscopy	0.46	0.15	0.20	0.15	0.20	0.01	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
71035		A	Chest x-ray	0.18	0.67	0.73	NA	NA	0.02	XXX
71035	TC	A	Chest x-ray	0.00	0.62	0.66	NA	NA	0.01	XXX
71035	26	A	Chest x-ray	0.18	0.05	0.07	0.05	0.07	0.01	XXX
71040		A	Contrast x-ray of bronchi	0.58	1.81	1.94	NA	NA	0.02	XXX
71040	TC	A	Contrast x-ray of bronchi	0.00	1.64	1.74	NA	NA	0.01	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.17	0.20	0.17	0.20	0.01	XXX
71060		A	Contrast x-ray of bronchi	0.74	2.81	2.95	NA	NA	0.04	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	2.58	2.68	NA	NA	0.01	XXX
71060	26	A	Contrast x-ray of bronchi	0.74	0.23	0.27	0.23	0.27	0.03	XXX
71090		C	X-ray & pacemaker insertion	0.00	0.00	0.00	NA	NA	0.00	XXX
71090	TC	C	X-ray & pacemaker insertion	0.00	0.00	0.00	NA	NA	0.00	XXX
71090	26	A	X-ray & pacemaker insertion	0.54	0.18	0.24	0.18	0.24	0.03	XXX
71100		A	X-ray exam of ribs	0.22	0.57	0.63	NA	NA	0.02	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.50	0.55	NA	NA	0.01	XXX
71100	26	A	X-ray exam of ribs	0.22	0.07	0.08	0.07	0.08	0.01	XXX
71101		A	X-ray exam of ribs/chest	0.27	0.70	0.76	NA	NA	0.02	XXX
71101	TC	A	X-ray exam of ribs/chest	0.00	0.61	0.67	NA	NA	0.01	XXX
71101	26	A	X-ray exam of ribs/chest	0.27	0.09	0.09	0.09	0.09	0.01	XXX
71110		A	X-ray exam of ribs	0.27	0.73	0.79	NA	NA	0.02	XXX
71110	TC	A	X-ray exam of ribs	0.00	0.64	0.70	NA	NA	0.01	XXX
71110	26	A	X-ray exam of ribs	0.27	0.09	0.09	0.09	0.09	0.01	XXX
71111		A	X-ray exam of ribs/chest	0.32	0.99	1.04	NA	NA	0.02	XXX
71111	TC	A	X-ray exam of ribs/chest	0.00	0.88	0.93	NA	NA	0.01	XXX
71111	26	A	X-ray exam of ribs/chest	0.32	0.11	0.11	0.11	0.11	0.01	XXX
71120		A	X-ray exam of breastbone	0.20	0.56	0.64	NA	NA	0.02	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.50	0.57	NA	NA	0.01	XXX
71120	26	A	X-ray exam of breastbone	0.20	0.06	0.07	0.06	0.07	0.01	XXX
71130		A	X-ray exam of breastbone	0.22	0.69	0.76	NA	NA	0.02	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.62	0.68	NA	NA	0.01	XXX
71130	26	A	X-ray exam of breastbone	0.22	0.07	0.08	0.07	0.08	0.01	XXX
71250		A	Ct thorax w/o dye	1.16	3.59	5.78	NA	NA	0.06	XXX
71250	TC	A	Ct thorax w/o dye	0.00	3.24	5.36	NA	NA	0.01	XXX
71250	26	A	Ct thorax w/o dye	1.16	0.35	0.42	0.35	0.42	0.05	XXX
71260		A	Ct thorax w/dye	1.24	4.46	7.10	NA	NA	0.06	XXX
71260	TC	A	Ct thorax w/dye	0.00	4.08	6.65	NA	NA	0.01	XXX
71260	26	A	Ct thorax w/dye	1.24	0.38	0.45	0.38	0.45	0.05	XXX
71270		A	Ct thorax w/o & w/dye	1.38	5.54	8.89	NA	NA	0.06	XXX
71270	TC	A	Ct thorax w/o & w/dye	0.00	5.12	8.39	NA	NA	0.01	XXX
71270	26	A	Ct thorax w/o & w/dye	1.38	0.42	0.50	0.42	0.50	0.05	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
71275		A	Ct angiography, chest	1.92	10.26	11.75	NA	NA	0.10	XXX
71275	TC	A	Ct angiography, chest	0.00	9.68	11.05	NA	NA	0.02	XXX
71275	26	A	Ct angiography, chest	1.92	0.58	0.70	0.58	0.70	0.08	XXX
71550		A	Mri chest w/o dye	1.46	8.41	13.62	NA	NA	0.07	XXX
71550	TC	A	Mri chest w/o dye	0.00	7.97	13.10	NA	NA	0.01	XXX
71550	26	A	Mri chest w/o dye	1.46	0.44	0.52	0.44	0.52	0.06	XXX
71551		A	Mri chest w/dye	1.73	9.49	15.20	NA	NA	0.09	XXX
71551	TC	A	Mri chest w/dye	0.00	8.96	14.59	NA	NA	0.02	XXX
71551	26	A	Mri chest w/dye	1.73	0.53	0.61	0.53	0.61	0.07	XXX
71552		A	Mri chest w/o & w/dye	2.26	11.71	20.63	NA	NA	0.11	XXX
71552	TC	A	Mri chest w/o & w/dye	0.00	11.03	19.81	NA	NA	0.02	XXX
71552	26	A	Mri chest w/o & w/dye	2.26	0.68	0.82	0.68	0.82	0.09	XXX
71555		R	Mri angio chest w or w/o dye	1.81	13.13	14.25	NA	NA	0.09	XXX
71555	TC	R	Mri angio chest w or w/o dye	0.00	12.58	13.58	NA	NA	0.02	XXX
71555	26	R	Mri angio chest w or w/o dye	1.81	0.55	0.67	0.55	0.67	0.07	XXX
72010		A	X-ray exam of spine	0.45	1.48	1.41	NA	NA	0.03	XXX
72010	TC	A	X-ray exam of spine	0.00	1.31	1.26	NA	NA	0.01	XXX
72010	26	A	X-ray exam of spine	0.45	0.17	0.15	0.17	0.15	0.02	XXX
72020		A	X-ray exam of spine	0.15	0.42	0.47	NA	NA	0.02	XXX
72020	TC	A	X-ray exam of spine	0.00	0.37	0.41	NA	NA	0.01	XXX
72020	26	A	X-ray exam of spine	0.15	0.05	0.06	0.05	0.06	0.01	XXX
72040		A	X-ray exam of neck spine	0.22	0.74	0.75	NA	NA	0.03	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.66	0.67	NA	NA	0.01	XXX
72040	26	A	X-ray exam of neck spine	0.22	0.08	0.08	0.08	0.08	0.02	XXX
72050		A	X-ray exam of neck spine	0.31	0.97	1.05	NA	NA	0.03	XXX
72050	TC	A	X-ray exam of neck spine	0.00	0.87	0.94	NA	NA	0.01	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.10	0.11	0.10	0.11	0.02	XXX
72052		A	X-ray exam of neck spine	0.36	1.29	1.36	NA	NA	0.03	XXX
72052	TC	A	X-ray exam of neck spine	0.00	1.17	1.23	NA	NA	0.01	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.12	0.13	0.12	0.13	0.02	XXX
72069		A	X-ray exam of trunk spine	0.22	0.71	0.71	NA	NA	0.03	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.63	0.63	NA	NA	0.01	XXX
72069	26	A	X-ray exam of trunk spine	0.22	0.08	0.08	0.08	0.08	0.02	XXX
72070		A	X-ray exam of thoracic spine	0.22	0.61	0.66	NA	NA	0.02	XXX
72070	TC	A	X-ray exam of thoracic spine	0.00	0.53	0.58	NA	NA	0.01	XXX
72070	26	A	X-ray exam of thoracic spine	0.22	0.08	0.08	0.08	0.08	0.01	XXX
72072		A	X-ray exam of thoracic spine	0.22	0.68	0.77	NA	NA	0.02	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.61	0.69	NA	NA	0.01	XXX
72072	26	A	X-ray exam of thoracic spine	0.22	0.07	0.08	0.07	0.08	0.01	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
72074		A	X-ray exam of thoracic spine	0.22	0.85	0.94	NA	NA	0.02	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.78	0.86	NA	NA	0.01	XXX
72074	26	A	X-ray exam of thoracic spine	0.22	0.07	0.08	0.07	0.08	0.01	XXX
72080		A	X-ray exam of trunk spine	0.22	0.68	0.70	NA	NA	0.03	XXX
72080	TC	A	X-ray exam of trunk spine	0.00	0.60	0.62	NA	NA	0.01	XXX
72080	26	A	X-ray exam of trunk spine	0.22	0.08	0.08	0.08	0.08	0.02	XXX
72090		A	X-ray exam of trunk spine	0.28	0.96	0.96	NA	NA	0.04	XXX
72090	TC	A	X-ray exam of trunk spine	0.00	0.86	0.85	NA	NA	0.01	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.10	0.11	0.10	0.11	0.03	XXX
72100		A	X-ray exam of lower spine	0.22	0.79	0.80	NA	NA	0.03	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.71	0.72	NA	NA	0.01	XXX
72100	26	A	X-ray exam of lower spine	0.22	0.08	0.08	0.08	0.08	0.02	XXX
72110		A	X-ray exam of lower spine	0.31	1.04	1.11	NA	NA	0.03	XXX
72110	TC	A	X-ray exam of lower spine	0.00	0.94	1.00	NA	NA	0.01	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.10	0.11	0.10	0.11	0.02	XXX
72114		A	X-ray exam of lower spine	0.36	1.51	1.52	NA	NA	0.04	XXX
72114	TC	A	X-ray exam of lower spine	0.00	1.38	1.39	NA	NA	0.01	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.13	0.13	0.13	0.13	0.03	XXX
72120		A	X-ray exam of lower spine	0.22	1.08	1.06	NA	NA	0.03	XXX
72120	TC	A	X-ray exam of lower spine	0.00	0.99	0.98	NA	NA	0.01	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.09	0.08	0.09	0.08	0.02	XXX
72125		A	Ct neck spine w/o dye	1.16	3.62	5.80	NA	NA	0.06	XXX
72125	TC	A	Ct neck spine w/o dye	0.00	3.27	5.38	NA	NA	0.01	XXX
72125	26	A	Ct neck spine w/o dye	1.16	0.35	0.42	0.35	0.42	0.05	XXX
72126		A	Ct neck spine w/dye	1.22	4.47	7.10	NA	NA	0.06	XXX
72126	TC	A	Ct neck spine w/dye	0.00	4.10	6.66	NA	NA	0.01	XXX
72126	26	A	Ct neck spine w/dye	1.22	0.37	0.44	0.37	0.44	0.05	XXX
72127		A	Ct neck spine w/o & w/dye	1.27	5.52	8.83	NA	NA	0.06	XXX
72127	TC	A	Ct neck spine w/o & w/dye	0.00	5.14	8.38	NA	NA	0.01	XXX
72127	26	A	Ct neck spine w/o & w/dye	1.27	0.38	0.45	0.38	0.45	0.05	XXX
72128		A	Ct chest spine w/o dye	1.16	3.61	5.79	NA	NA	0.06	XXX
72128	TC	A	Ct chest spine w/o dye	0.00	3.26	5.37	NA	NA	0.01	XXX
72128	26	A	Ct chest spine w/o dye	1.16	0.35	0.42	0.35	0.42	0.05	XXX
72129		A	Ct chest spine w/dye	1.22	4.48	7.10	NA	NA	0.06	XXX
72129	TC	A	Ct chest spine w/dye	0.00	4.11	6.66	NA	NA	0.01	XXX
72129	26	A	Ct chest spine w/dye	1.22	0.37	0.44	0.37	0.44	0.05	XXX
72130		A	Ct chest spine w/o & w/dye	1.27	5.57	8.87	NA	NA	0.06	XXX
72130	TC	A	Ct chest spine w/o & w/dye	0.00	5.18	8.41	NA	NA	0.01	XXX
72130	26	A	Ct chest spine w/o & w/dye	1.27	0.39	0.46	0.39	0.46	0.05	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
72131		A	Ct lumbar spine w/o dye	1.16	3.60	5.78	NA	NA	0.06	XXX
72131	TC	A	Ct lumbar spine w/o dye	0.00	3.25	5.36	NA	NA	0.01	XXX
72131	26	A	Ct lumbar spine w/o dye	1.16	0.35	0.42	0.35	0.42	0.05	XXX
72132		A	Ct lumbar spine w/dye	1.22	4.46	7.09	NA	NA	0.06	XXX
72132	TC	A	Ct lumbar spine w/dye	0.00	4.09	6.65	NA	NA	0.01	XXX
72132	26	A	Ct lumbar spine w/dye	1.22	0.37	0.44	0.37	0.44	0.05	XXX
72133		A	Ct lumbar spine w/o & w/dye	1.27	5.53	8.85	NA	NA	0.06	XXX
72133	TC	A	Ct lumbar spine w/o & w/dye	0.00	5.14	8.39	NA	NA	0.01	XXX
72133	26	A	Ct lumbar spine w/o & w/dye	1.27	0.39	0.46	0.39	0.46	0.05	XXX
72141		A	Mri neck spine w/o dye	1.60	6.59	10.98	NA	NA	0.08	XXX
72141	TC	A	Mri neck spine w/o dye	0.00	6.09	10.41	NA	NA	0.01	XXX
72141	26	A	Mri neck spine w/o dye	1.60	0.50	0.57	0.50	0.57	0.07	XXX
72142		A	Mri neck spine w/dye	1.92	8.54	13.71	NA	NA	0.09	XXX
72142	TC	A	Mri neck spine w/dye	0.00	7.94	13.02	NA	NA	0.01	XXX
72142	26	A	Mri neck spine w/dye	1.92	0.60	0.69	0.60	0.69	0.08	XXX
72146		A	Mri chest spine w/o dye	1.60	6.60	11.24	NA	NA	0.08	XXX
72146	TC	A	Mri chest spine w/o dye	0.00	6.11	10.66	NA	NA	0.01	XXX
72146	26	A	Mri chest spine w/o dye	1.60	0.49	0.58	0.49	0.58	0.07	XXX
72147		A	Mri chest spine w/dye	1.92	7.42	12.27	NA	NA	0.09	XXX
72147	TC	A	Mri chest spine w/dye	0.00	6.83	11.58	NA	NA	0.01	XXX
72147	26	A	Mri chest spine w/dye	1.92	0.59	0.69	0.59	0.69	0.08	XXX
72148		A	Mri lumbar spine w/o dye	1.48	6.56	11.18	NA	NA	0.08	XXX
72148	TC	A	Mri lumbar spine w/o dye	0.00	6.10	10.65	NA	NA	0.01	XXX
72148	26	A	Mri lumbar spine w/o dye	1.48	0.46	0.53	0.46	0.53	0.07	XXX
72149		A	Mri lumbar spine w/dye	1.78	8.38	13.63	NA	NA	0.09	XXX
72149	TC	A	Mri lumbar spine w/dye	0.00	7.83	12.99	NA	NA	0.01	XXX
72149	26	A	Mri lumbar spine w/dye	1.78	0.55	0.64	0.55	0.64	0.08	XXX
72156		A	Mri neck spine w/o & w/dye	2.57	9.60	17.43	NA	NA	0.12	XXX
72156	TC	A	Mri neck spine w/o & w/dye	0.00	8.81	16.51	NA	NA	0.01	XXX
72156	26	A	Mri neck spine w/o & w/dye	2.57	0.79	0.92	0.79	0.92	0.11	XXX
72157		A	Mri chest spine w/o & w/dye	2.57	8.78	16.34	NA	NA	0.12	XXX
72157	TC	A	Mri chest spine w/o & w/dye	0.00	8.00	15.42	NA	NA	0.01	XXX
72157	26	A	Mri chest spine w/o & w/dye	2.57	0.78	0.92	0.78	0.92	0.11	XXX
72158		A	Mri lumbar spine w/o & w/dye	2.36	9.49	17.33	NA	NA	0.12	XXX
72158	TC	A	Mri lumbar spine w/o & w/dye	0.00	8.76	16.49	NA	NA	0.01	XXX
72158	26	A	Mri lumbar spine w/o & w/dye	2.36	0.73	0.84	0.73	0.84	0.11	XXX
72159		N	Mr angio spine w/o&w/dye	1.80	15.76	15.80	NA	NA	0.06	XXX
72159	TC	N	Mr angio spine w/o&w/dye	0.00	15.10	15.15	NA	NA	0.02	XXX
72159	26	N	Mr angio spine w/o&w/dye	1.80	0.66	0.65	0.66	0.65	0.04	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
72170		A	X-ray exam of pelvis	0.17	0.47	0.51	NA	NA	0.03	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.41	0.45	NA	NA	0.01	XXX
72170	26	A	X-ray exam of pelvis	0.17	0.06	0.06	0.06	0.06	0.02	XXX
72190		A	X-ray exam of pelvis	0.21	0.82	0.83	NA	NA	0.03	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.74	0.75	NA	NA	0.01	XXX
72190	26	A	X-ray exam of pelvis	0.21	0.08	0.08	0.08	0.08	0.02	XXX
72191		A	Ct angiograph pelv w/o&w/dye	1.81	9.88	11.35	NA	NA	0.11	XXX
72191	TC	A	Ct angiograph pelv w/o&w/dye	0.00	9.34	10.69	NA	NA	0.02	XXX
72191	26	A	Ct angiograph pelv w/o&w/dye	1.81	0.54	0.66	0.54	0.66	0.09	XXX
72192		A	Ct pelvis w/o dye	1.09	3.34	5.48	NA	NA	0.05	XXX
72192	TC	A	Ct pelvis w/o dye	0.00	3.01	5.08	NA	NA	0.01	XXX
72192	26	A	Ct pelvis w/o dye	1.09	0.33	0.40	0.33	0.40	0.04	XXX
72193		A	Ct pelvis w/dye	1.16	4.19	6.73	NA	NA	0.06	XXX
72193	TC	A	Ct pelvis w/dye	0.00	3.84	6.31	NA	NA	0.01	XXX
72193	26	A	Ct pelvis w/dye	1.16	0.35	0.42	0.35	0.42	0.05	XXX
72194		A	Ct pelvis w/o & w/dye	1.22	5.56	8.87	NA	NA	0.06	XXX
72194	TC	A	Ct pelvis w/o & w/dye	0.00	5.19	8.43	NA	NA	0.01	XXX
72194	26	A	Ct pelvis w/o & w/dye	1.22	0.37	0.44	0.37	0.44	0.05	XXX
72195		A	Mri pelvis w/o dye	1.46	7.54	12.31	NA	NA	0.08	XXX
72195	TC	A	Mri pelvis w/o dye	0.00	7.09	11.79	NA	NA	0.01	XXX
72195	26	A	Mri pelvis w/o dye	1.46	0.45	0.52	0.45	0.52	0.07	XXX
72196		A	Mri pelvis w/dye	1.73	8.34	13.53	NA	NA	0.08	XXX
72196	TC	A	Mri pelvis w/dye	0.00	7.81	12.91	NA	NA	0.01	XXX
72196	26	A	Mri pelvis w/dye	1.73	0.53	0.62	0.53	0.62	0.07	XXX
72197		A	Mri pelvis w/o & w/dye	2.26	10.01	18.17	NA	NA	0.11	XXX
72197	TC	A	Mri pelvis w/o & w/dye	0.00	9.33	17.36	NA	NA	0.02	XXX
72197	26	A	Mri pelvis w/o & w/dye	2.26	0.68	0.81	0.68	0.81	0.09	XXX
72198		A	Mr angio pelvis w/o & w/dye	1.80	13.15	14.18	NA	NA	0.09	XXX
72198	TC	A	Mr angio pelvis w/o & w/dye	0.00	12.61	13.53	NA	NA	0.02	XXX
72198	26	A	Mr angio pelvis w/o & w/dye	1.80	0.54	0.65	0.54	0.65	0.07	XXX
72200		A	X-ray exam sacroiliac joints	0.17	0.55	0.59	NA	NA	0.02	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.49	0.53	NA	NA	0.01	XXX
72200	26	A	X-ray exam sacroiliac joints	0.17	0.06	0.06	0.06	0.06	0.01	XXX
72202		A	X-ray exam sacroiliac joints	0.19	0.65	0.71	NA	NA	0.02	XXX
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.59	0.64	NA	NA	0.01	XXX
72202	26	A	X-ray exam sacroiliac joints	0.19	0.06	0.07	0.06	0.07	0.01	XXX
72220		A	X-ray exam of tailbone	0.17	0.54	0.59	NA	NA	0.02	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.48	0.53	NA	NA	0.01	XXX
72220	26	A	X-ray exam of tailbone	0.17	0.06	0.06	0.06	0.06	0.01	XXX

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72240		A	Contrast x-ray of neck spine	0.91	2.30	3.01	NA	NA	0.05	XXX
72240	TC	A	Contrast x-ray of neck spine	0.00	2.02	2.69	NA	NA	0.01	XXX
72240	26	A	Contrast x-ray of neck spine	0.91	0.28	0.32	0.28	0.32	0.04	XXX
72255		A	Contrast x-ray, thorax spine	0.91	2.25	2.74	NA	NA	0.04	XXX
72255	TC	A	Contrast x-ray, thorax spine	0.00	1.95	2.43	NA	NA	0.01	XXX
72255	26	A	Contrast x-ray, thorax spine	0.91	0.30	0.31	0.30	0.31	0.03	XXX
72265		A	Contrast x-ray, lower spine	0.83	2.31	2.87	NA	NA	0.04	XXX
72265	TC	A	Contrast x-ray, lower spine	0.00	2.05	2.57	NA	NA	0.01	XXX
72265	26	A	Contrast x-ray, lower spine	0.83	0.26	0.30	0.26	0.30	0.03	XXX
72270		A	Contrast x-ray, spine	1.33	3.56	4.44	NA	NA	0.06	XXX
72270	TC	A	Contrast x-ray, spine	0.00	3.14	3.96	NA	NA	0.01	XXX
72270	26	A	Contrast x-ray, spine	1.33	0.42	0.48	0.42	0.48	0.05	XXX
72275		A	Epidurography	0.76	2.20	2.00	NA	NA	0.04	XXX
72275	TC	A	Epidurography	0.00	1.90	1.76	NA	NA	0.01	XXX
72275	26	A	Epidurography	0.76	0.30	0.24	0.30	0.24	0.03	XXX
72285		A	X-ray c/t spine disk	1.16	1.89	2.99	NA	NA	0.05	XXX
72285	TC	A	X-ray c/t spine disk	0.00	1.40	2.61	NA	NA	0.01	XXX
72285	26	A	X-ray c/t spine disk	1.16	0.49	0.38	0.49	0.38	0.04	XXX
72291		C	Perq verte/sacroplsty, fluor	0.00	0.00	0.00	NA	NA	0.00	XXX
72291	TC	C	Perq verte/sacroplsty, fluor	0.00	0.00	0.00	NA	NA	0.00	XXX
72291	26	A	Perq verte/sacroplsty, fluor	1.31	0.49	0.51	0.49	0.51	0.15	XXX
72292		C	Perq verte/sacroplsty, ct	0.00	0.00	0.00	NA	NA	0.00	XXX
72292	TC	C	Perq verte/sacroplsty, ct	0.00	0.00	0.00	NA	NA	0.00	XXX
72292	26	A	Perq verte/sacroplsty, ct	1.38	0.49	0.54	0.49	0.54	0.14	XXX
72295		A	X-ray of lower spine disk	0.83	1.76	2.83	NA	NA	0.04	XXX
72295	TC	A	X-ray of lower spine disk	0.00	1.42	2.55	NA	NA	0.01	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.34	0.28	0.34	0.28	0.03	XXX
73000		A	X-ray exam of collar bone	0.16	0.55	0.57	NA	NA	0.02	XXX
73000	TC	A	X-ray exam of collar bone	0.00	0.49	0.51	NA	NA	0.01	XXX
73000	26	A	X-ray exam of collar bone	0.16	0.06	0.06	0.06	0.06	0.01	XXX
73010		A	X-ray exam of shoulder blade	0.17	0.60	0.58	NA	NA	0.03	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.53	0.52	NA	NA	0.01	XXX
73010	26	A	X-ray exam of shoulder blade	0.17	0.07	0.06	0.07	0.06	0.02	XXX
73020		A	X-ray exam of shoulder	0.15	0.44	0.46	NA	NA	0.02	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.38	0.41	NA	NA	0.01	XXX
73020	26	A	X-ray exam of shoulder	0.15	0.06	0.05	0.06	0.05	0.01	XXX
73030		A	X-ray exam of shoulder	0.18	0.57	0.59	NA	NA	0.03	XXX
73030	TC	A	X-ray exam of shoulder	0.00	0.50	0.52	NA	NA	0.01	XXX
73030	26	A	X-ray exam of shoulder	0.18	0.07	0.07	0.07	0.07	0.02	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
73040		A	Contrast x-ray of shoulder	0.54	2.08	2.25	NA	NA	0.04	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	1.90	2.05	NA	NA	0.01	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.18	0.20	0.18	0.20	0.03	XXX
73050		A	X-ray exam of shoulders	0.20	0.76	0.75	NA	NA	0.03	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.68	0.67	NA	NA	0.01	XXX
73050	26	A	X-ray exam of shoulders	0.20	0.08	0.08	0.08	0.08	0.02	XXX
73060		A	X-ray exam of humerus	0.17	0.54	0.58	NA	NA	0.03	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.48	0.52	NA	NA	0.01	XXX
73060	26	A	X-ray exam of humerus	0.17	0.06	0.06	0.06	0.06	0.02	XXX
73070		A	X-ray exam of elbow	0.15	0.55	0.56	NA	NA	0.02	XXX
73070	TC	A	X-ray exam of elbow	0.00	0.49	0.51	NA	NA	0.01	XXX
73070	26	A	X-ray exam of elbow	0.15	0.06	0.05	0.06	0.05	0.01	XXX
73080		A	X-ray exam of elbow	0.17	0.71	0.73	NA	NA	0.02	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.65	0.67	NA	NA	0.01	XXX
73080	26	A	X-ray exam of elbow	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73085		A	Contrast x-ray of elbow	0.54	1.84	1.97	NA	NA	0.03	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	1.65	1.78	NA	NA	0.01	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.19	0.19	0.19	0.19	0.02	XXX
73090		A	X-ray exam of forearm	0.16	0.52	0.55	NA	NA	0.02	XXX
73090	TC	A	X-ray exam of forearm	0.00	0.46	0.50	NA	NA	0.01	XXX
73090	26	A	X-ray exam of forearm	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73092		A	X-ray exam of arm, infant	0.16	0.58	0.58	NA	NA	0.02	XXX
73092	TC	A	X-ray exam of arm, infant	0.00	0.53	0.53	NA	NA	0.01	XXX
73092	26	A	X-ray exam of arm, infant	0.16	0.05	0.05	0.05	0.05	0.01	XXX
73100		A	X-ray exam of wrist	0.16	0.62	0.60	NA	NA	0.03	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.55	0.54	NA	NA	0.01	XXX
73100	26	A	X-ray exam of wrist	0.16	0.07	0.06	0.07	0.06	0.02	XXX
73110		A	X-ray exam of wrist	0.17	0.75	0.74	NA	NA	0.02	XXX
73110	TC	A	X-ray exam of wrist	0.00	0.69	0.68	NA	NA	0.01	XXX
73110	26	A	X-ray exam of wrist	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73115		A	Contrast x-ray of wrist	0.54	2.21	2.19	NA	NA	0.04	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	2.01	1.99	NA	NA	0.01	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.20	0.20	0.20	0.20	0.03	XXX
73120		A	X-ray exam of hand	0.16	0.52	0.54	NA	NA	0.02	XXX
73120	TC	A	X-ray exam of hand	0.00	0.46	0.49	NA	NA	0.01	XXX
73120	26	A	X-ray exam of hand	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73130		A	X-ray exam of hand	0.17	0.62	0.65	NA	NA	0.02	XXX
73130	TC	A	X-ray exam of hand	0.00	0.56	0.59	NA	NA	0.01	XXX
73130	26	A	X-ray exam of hand	0.17	0.06	0.06	0.06	0.06	0.01	XXX

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73140		A	X-ray exam of finger(s)	0.13	0.68	0.65	NA	NA	0.02	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.63	0.60	NA	NA	0.01	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.05	0.05	0.05	0.05	0.01	XXX
73200		A	Ct upper extremity w/o dye	1.09	3.56	5.55	NA	NA	0.06	XXX
73200	TC	A	Ct upper extremity w/o dye	0.00	3.23	5.16	NA	NA	0.01	XXX
73200	26	A	Ct upper extremity w/o dye	1.09	0.33	0.39	0.33	0.39	0.05	XXX
73201		A	Ct upper extremity w/dye	1.16	4.41	6.81	NA	NA	0.06	XXX
73201	TC	A	Ct upper extremity w/dye	0.00	4.06	6.39	NA	NA	0.01	XXX
73201	26	A	Ct upper extremity w/dye	1.16	0.35	0.42	0.35	0.42	0.05	XXX
73202		A	Ct uppr extremity w/o&w/dye	1.22	5.82	8.98	NA	NA	0.06	XXX
73202	TC	A	Ct uppr extremity w/o&w/dye	0.00	5.45	8.54	NA	NA	0.01	XXX
73202	26	A	Ct uppr extremity w/o&w/dye	1.22	0.37	0.44	0.37	0.44	0.05	XXX
73206		A	Ct angio upr extrm w/o&w/dye	1.81	9.36	10.77	NA	NA	0.08	XXX
73206	TC	A	Ct angio upr extrm w/o&w/dye	0.00	8.81	10.10	NA	NA	0.02	XXX
73206	26	A	Ct angio upr extrm w/o&w/dye	1.81	0.55	0.67	0.55	0.67	0.06	XXX
73218		A	Mri upper extremity w/o dye	1.35	7.54	12.43	NA	NA	0.06	XXX
73218	TC	A	Mri upper extremity w/o dye	0.00	7.11	11.96	NA	NA	0.01	XXX
73218	26	A	Mri upper extremity w/o dye	1.35	0.43	0.47	0.43	0.47	0.05	XXX
73219		A	Mri upper extremity w/dye	1.62	8.30	13.53	NA	NA	0.08	XXX
73219	TC	A	Mri upper extremity w/dye	0.00	7.80	12.95	NA	NA	0.01	XXX
73219	26	A	Mri upper extremity w/dye	1.62	0.50	0.58	0.50	0.58	0.07	XXX
73220		A	Mri uppr extremity w/o&w/dye	2.15	10.10	18.22	NA	NA	0.11	XXX
73220	TC	A	Mri uppr extremity w/o&w/dye	0.00	9.44	17.45	NA	NA	0.02	XXX
73220	26	A	Mri uppr extremity w/o&w/dye	2.15	0.66	0.77	0.66	0.77	0.09	XXX
73221		A	Mri joint upr extrem w/o dye	1.35	7.14	11.69	NA	NA	0.08	XXX
73221	TC	A	Mri joint upr extrem w/o dye	0.00	6.70	11.21	NA	NA	0.01	XXX
73221	26	A	Mri joint upr extrem w/o dye	1.35	0.44	0.48	0.44	0.48	0.07	XXX
73222		A	Mri joint upr extrem w/dye	1.62	7.69	12.73	NA	NA	0.08	XXX
73222	TC	A	Mri joint upr extrem w/dye	0.00	7.18	12.15	NA	NA	0.01	XXX
73222	26	A	Mri joint upr extrem w/dye	1.62	0.51	0.58	0.51	0.58	0.07	XXX
73223		A	Mri joint upr extr w/o&w/dye	2.15	9.44	17.27	NA	NA	0.10	XXX
73223	TC	A	Mri joint upr extr w/o&w/dye	0.00	8.77	16.51	NA	NA	0.01	XXX
73223	26	A	Mri joint upr extr w/o&w/dye	2.15	0.67	0.76	0.67	0.76	0.09	XXX
73225		N	Mr angio upr extr w/o&w/dye	1.73	15.73	15.53	NA	NA	0.06	XXX
73225	TC	N	Mr angio upr extr w/o&w/dye	0.00	15.10	14.91	NA	NA	0.02	XXX
73225	26	N	Mr angio upr extr w/o&w/dye	1.73	0.63	0.62	0.63	0.62	0.04	XXX
73500		A	X-ray exam of hip	0.17	0.49	0.49	NA	NA	0.03	XXX
73500	TC	A	X-ray exam of hip	0.00	0.42	0.43	NA	NA	0.01	XXX
73500	26	A	X-ray exam of hip	0.17	0.07	0.06	0.07	0.06	0.02	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
73510		A	X-ray exam of hip	0.21	0.75	0.75	NA	NA	0.03	XXX
73510	TC	A	X-ray exam of hip	0.00	0.67	0.67	NA	NA	0.01	XXX
73510	26	A	X-ray exam of hip	0.21	0.08	0.08	0.08	0.08	0.02	XXX
73520		A	X-ray exam of hips	0.26	0.75	0.77	NA	NA	0.03	XXX
73520	TC	A	X-ray exam of hips	0.00	0.65	0.68	NA	NA	0.01	XXX
73520	26	A	X-ray exam of hips	0.26	0.10	0.09	0.10	0.09	0.02	XXX
73525		A	Contrast x-ray of hip	0.54	1.97	2.00	NA	NA	0.04	XXX
73525	TC	A	Contrast x-ray of hip	0.00	1.76	1.79	NA	NA	0.01	XXX
73525	26	A	Contrast x-ray of hip	0.54	0.21	0.21	0.21	0.21	0.03	XXX
73530		C	X-ray exam of hip	0.00	0.00	0.00	NA	NA	0.00	XXX
73530	TC	C	X-ray exam of hip	0.00	0.00	0.00	NA	NA	0.00	XXX
73530	26	A	X-ray exam of hip	0.29	0.09	0.11	0.09	0.11	0.02	XXX
73540		A	X-ray exam of pelvis & hips	0.20	0.89	0.80	NA	NA	0.03	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.80	0.72	NA	NA	0.01	XXX
73540	26	A	X-ray exam of pelvis & hips	0.20	0.09	0.08	0.09	0.08	0.02	XXX
73542		A	X-ray exam, sacroiliac joint	0.59	1.57	1.49	NA	NA	0.03	XXX
73542	TC	A	X-ray exam, sacroiliac joint	0.00	1.32	1.31	NA	NA	0.01	XXX
73542	26	A	X-ray exam, sacroiliac joint	0.59	0.25	0.18	0.25	0.18	0.02	XXX
73550		A	X-ray exam of thigh	0.17	0.51	0.56	NA	NA	0.03	XXX
73550	TC	A	X-ray exam of thigh	0.00	0.45	0.50	NA	NA	0.01	XXX
73550	26	A	X-ray exam of thigh	0.17	0.06	0.06	0.06	0.06	0.02	XXX
73560		A	X-ray exam of knee, 1 or 2	0.17	0.59	0.58	NA	NA	0.03	XXX
73560	TC	A	X-ray exam of knee, 1 or 2	0.00	0.52	0.52	NA	NA	0.01	XXX
73560	26	A	X-ray exam of knee, 1 or 2	0.17	0.07	0.06	0.07	0.06	0.02	XXX
73562		A	X-ray exam of knee, 3	0.18	0.73	0.72	NA	NA	0.03	XXX
73562	TC	A	X-ray exam of knee, 3	0.00	0.66	0.65	NA	NA	0.01	XXX
73562	26	A	X-ray exam of knee, 3	0.18	0.07	0.07	0.07	0.07	0.02	XXX
73564		A	X-ray exam, knee, 4 or more	0.22	0.85	0.83	NA	NA	0.03	XXX
73564	TC	A	X-ray exam, knee, 4 or more	0.00	0.76	0.75	NA	NA	0.01	XXX
73564	26	A	X-ray exam, knee, 4 or more	0.22	0.09	0.08	0.09	0.08	0.02	XXX
73565		A	X-ray exam of knees	0.17	0.70	0.65	NA	NA	0.03	XXX
73565	TC	A	X-ray exam of knees	0.00	0.62	0.58	NA	NA	0.01	XXX
73565	26	A	X-ray exam of knees	0.17	0.08	0.07	0.08	0.07	0.02	XXX
73580		A	Contrast x-ray of knee joint	0.54	2.88	2.71	NA	NA	0.05	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	2.63	2.49	NA	NA	0.01	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.25	0.22	0.25	0.22	0.04	XXX
73590		A	X-ray exam of lower leg	0.17	0.51	0.54	NA	NA	0.02	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.45	0.48	NA	NA	0.01	XXX
73590	26	A	X-ray exam of lower leg	0.17	0.06	0.06	0.06	0.06	0.01	XXX

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73592		A	X-ray exam of leg, infant	0.16	0.62	0.59	NA	NA	0.02	XXX
73592	TC	A	X-ray exam of leg, infant	0.00	0.56	0.54	NA	NA	0.01	XXX
73592	26	A	X-ray exam of leg, infant	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73600		A	X-ray exam of ankle	0.16	0.56	0.55	NA	NA	0.02	XXX
73600	TC	A	X-ray exam of ankle	0.00	0.50	0.50	NA	NA	0.01	XXX
73600	26	A	X-ray exam of ankle	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73610		A	X-ray exam of ankle	0.17	0.65	0.65	NA	NA	0.02	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.59	0.59	NA	NA	0.01	XXX
73610	26	A	X-ray exam of ankle	0.17	0.06	0.06	0.06	0.06	0.01	XXX
73615		A	Contrast x-ray of ankle	0.54	2.13	2.09	NA	NA	0.04	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	1.91	1.89	NA	NA	0.01	XXX
73615	26	A	Contrast x-ray of ankle	0.54	0.22	0.20	0.22	0.20	0.03	XXX
73620		A	X-ray exam of foot	0.16	0.53	0.53	NA	NA	0.02	XXX
73620	TC	A	X-ray exam of foot	0.00	0.48	0.48	NA	NA	0.01	XXX
73620	26	A	X-ray exam of foot	0.16	0.05	0.05	0.05	0.05	0.01	XXX
73630		A	X-ray exam of foot	0.17	0.63	0.64	NA	NA	0.02	XXX
73630	TC	A	X-ray exam of foot	0.00	0.58	0.58	NA	NA	0.01	XXX
73630	26	A	X-ray exam of foot	0.17	0.05	0.06	0.05	0.06	0.01	XXX
73650		A	X-ray exam of heel	0.16	0.55	0.54	NA	NA	0.02	XXX
73650	TC	A	X-ray exam of heel	0.00	0.49	0.49	NA	NA	0.01	XXX
73650	26	A	X-ray exam of heel	0.16	0.06	0.05	0.06	0.05	0.01	XXX
73660		A	X-ray exam of toe(s)	0.13	0.62	0.60	NA	NA	0.02	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.57	0.56	NA	NA	0.01	XXX
73660	26	A	X-ray exam of toe(s)	0.13	0.05	0.04	0.05	0.04	0.01	XXX
73700		A	Ct lower extremity w/o dye	1.09	3.57	5.56	NA	NA	0.05	XXX
73700	TC	A	Ct lower extremity w/o dye	0.00	3.24	5.17	NA	NA	0.01	XXX
73700	26	A	Ct lower extremity w/o dye	1.09	0.33	0.39	0.33	0.39	0.04	XXX
73701		A	Ct lower extremity w/dye	1.16	4.46	6.86	NA	NA	0.06	XXX
73701	TC	A	Ct lower extremity w/dye	0.00	4.11	6.44	NA	NA	0.01	XXX
73701	26	A	Ct lower extremity w/dye	1.16	0.35	0.42	0.35	0.42	0.05	XXX
73702		A	Ct lwr extremity w/o&w/dye	1.22	5.86	9.00	NA	NA	0.06	XXX
73702	TC	A	Ct lwr extremity w/o&w/dye	0.00	5.49	8.56	NA	NA	0.01	XXX
73702	26	A	Ct lwr extremity w/o&w/dye	1.22	0.37	0.44	0.37	0.44	0.05	XXX
73706		A	Ct angio lwr extr w/o&w/dye	1.90	10.51	11.87	NA	NA	0.10	XXX
73706	TC	A	Ct angio lwr extr w/o&w/dye	0.00	9.93	11.16	NA	NA	0.02	XXX
73706	26	A	Ct angio lwr extr w/o&w/dye	1.90	0.58	0.71	0.58	0.71	0.08	XXX
73718		A	Mri lower extremity w/o dye	1.35	7.43	12.20	NA	NA	0.07	XXX
73718	TC	A	Mri lower extremity w/o dye	0.00	7.01	11.72	NA	NA	0.01	XXX
73718	26	A	Mri lower extremity w/o dye	1.35	0.42	0.48	0.42	0.48	0.06	XXX

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73719		A	Mri lower extremity w/dye	1.62	8.21	13.36	NA	NA	0.08	XXX
73719	TC	A	Mri lower extremity w/dye	0.00	7.72	12.79	NA	NA	0.01	XXX
73719	26	A	Mri lower extremity w/dye	1.62	0.49	0.57	0.49	0.57	0.07	XXX
73720		A	Mri lwr extremity w/o&w/dye	2.15	10.11	18.22	NA	NA	0.11	XXX
73720	TC	A	Mri lwr extremity w/o&w/dye	0.00	9.46	17.45	NA	NA	0.02	XXX
73720	26	A	Mri lwr extremity w/o&w/dye	2.15	0.65	0.77	0.65	0.77	0.09	XXX
73721		A	Mri jnt of lwr extre w/o dye	1.35	7.33	11.93	NA	NA	0.08	XXX
73721	TC	A	Mri jnt of lwr extre w/o dye	0.00	6.89	11.45	NA	NA	0.01	XXX
73721	26	A	Mri jnt of lwr extre w/o dye	1.35	0.44	0.48	0.44	0.48	0.07	XXX
73722		A	Mri joint of lwr extr w/dye	1.62	7.86	12.87	NA	NA	0.09	XXX
73722	TC	A	Mri joint of lwr extr w/dye	0.00	7.35	12.28	NA	NA	0.01	XXX
73722	26	A	Mri joint of lwr extr w/dye	1.62	0.51	0.59	0.51	0.59	0.08	XXX
73723		A	Mri joint lwr extr w/o&w/dye	2.15	9.42	17.23	NA	NA	0.10	XXX
73723	TC	A	Mri joint lwr extr w/o&w/dye	0.00	8.76	16.46	NA	NA	0.01	XXX
73723	26	A	Mri joint lwr extr w/o&w/dye	2.15	0.66	0.77	0.66	0.77	0.09	XXX
73725		R	Mr ang lwr ext w or w/o dye	1.82	13.18	14.19	NA	NA	0.09	XXX
73725	TC	R	Mr ang lwr ext w or w/o dye	0.00	12.63	13.53	NA	NA	0.02	XXX
73725	26	R	Mr ang lwr ext w or w/o dye	1.82	0.55	0.66	0.55	0.66	0.07	XXX
74000		A	X-ray exam of abdomen	0.18	0.41	0.48	NA	NA	0.02	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.35	0.42	NA	NA	0.01	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.06	0.06	0.06	0.06	0.01	XXX
74010		A	X-ray exam of abdomen	0.23	0.70	0.75	NA	NA	0.02	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.63	0.67	NA	NA	0.01	XXX
74010	26	A	X-ray exam of abdomen	0.23	0.07	0.08	0.07	0.08	0.01	XXX
74020		A	X-ray exam of abdomen	0.27	0.71	0.78	NA	NA	0.02	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.63	0.68	NA	NA	0.01	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.08	0.10	0.08	0.10	0.01	XXX
74022		A	X-ray exam series, abdomen	0.32	0.86	0.95	NA	NA	0.02	XXX
74022	TC	A	X-ray exam series, abdomen	0.00	0.76	0.83	NA	NA	0.01	XXX
74022	26	A	X-ray exam series, abdomen	0.32	0.10	0.12	0.10	0.12	0.01	XXX
74150		A	Ct abdomen w/o dye	1.19	3.38	5.47	NA	NA	0.06	XXX
74150	TC	A	Ct abdomen w/o dye	0.00	3.02	5.04	NA	NA	0.01	XXX
74150	26	A	Ct abdomen w/o dye	1.19	0.36	0.43	0.36	0.43	0.05	XXX
74160		A	Ct abdomen w/dye	1.27	4.89	7.64	NA	NA	0.06	XXX
74160	TC	A	Ct abdomen w/dye	0.00	4.50	7.18	NA	NA	0.01	XXX
74160	26	A	Ct abdomen w/dye	1.27	0.39	0.46	0.39	0.46	0.05	XXX
74170		A	Ct abdomen w/o & w/dye	1.40	6.71	10.33	NA	NA	0.07	XXX
74170	TC	A	Ct abdomen w/o & w/dye	0.00	6.28	9.82	NA	NA	0.01	XXX
74170	26	A	Ct abdomen w/o & w/dye	1.40	0.43	0.51	0.43	0.51	0.06	XXX

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74175		A	Ct angio abdom w/o & w/dye	1.90	10.68	12.09	NA	NA	0.11	XXX
74175	TC	A	Ct angio abdom w/o & w/dye	0.00	10.11	11.40	NA	NA	0.02	XXX
74175	26	A	Ct angio abdom w/o & w/dye	1.90	0.57	0.69	0.57	0.69	0.09	XXX
74181		A	Mri abdomen w/o dye	1.46	6.54	10.95	NA	NA	0.07	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	6.10	10.43	NA	NA	0.01	XXX
74181	26	A	Mri abdomen w/o dye	1.46	0.44	0.52	0.44	0.52	0.06	XXX
74182		A	Mri abdomen w/dye	1.73	9.25	14.88	NA	NA	0.08	XXX
74182	TC	A	Mri abdomen w/dye	0.00	8.73	14.26	NA	NA	0.01	XXX
74182	26	A	Mri abdomen w/dye	1.73	0.52	0.62	0.52	0.62	0.07	XXX
74183		A	Mri abdomen w/o & w/dye	2.26	10.05	18.20	NA	NA	0.11	XXX
74183	TC	A	Mri abdomen w/o & w/dye	0.00	9.37	17.39	NA	NA	0.02	XXX
74183	26	A	Mri abdomen w/o & w/dye	2.26	0.68	0.81	0.68	0.81	0.09	XXX
74185		R	Mri angio, abdom w orw/o dye	1.80	13.08	14.13	NA	NA	0.09	XXX
74185	TC	R	Mri angio, abdom w orw/o dye	0.00	12.54	13.48	NA	NA	0.02	XXX
74185	26	R	Mri angio, abdom w orw/o dye	1.80	0.54	0.65	0.54	0.65	0.07	XXX
74190		C	X-ray exam of peritoneum	0.00	0.00	0.00	NA	NA	0.00	XXX
74190	TC	C	X-ray exam of peritoneum	0.00	0.00	0.00	NA	NA	0.00	XXX
74190	26	A	X-ray exam of peritoneum	0.48	0.14	0.17	0.14	0.17	0.03	XXX
74210		A	Contrst x-ray exam of throat	0.36	1.55	1.65	NA	NA	0.02	XXX
74210	TC	A	Contrst x-ray exam of throat	0.00	1.44	1.52	NA	NA	0.01	XXX
74210	26	A	Contrst x-ray exam of throat	0.36	0.11	0.13	0.11	0.13	0.01	XXX
74220		A	Contrast x-ray, esophagus	0.46	1.78	1.86	NA	NA	0.03	XXX
74220	TC	A	Contrast x-ray, esophagus	0.00	1.64	1.69	NA	NA	0.01	XXX
74220	26	A	Contrast x-ray, esophagus	0.46	0.14	0.17	0.14	0.17	0.02	XXX
74230		A	Cine/vid x-ray, throat/esoph	0.53	1.71	1.83	NA	NA	0.03	XXX
74230	TC	A	Cine/vid x-ray, throat/esoph	0.00	1.55	1.64	NA	NA	0.01	XXX
74230	26	A	Cine/vid x-ray, throat/esoph	0.53	0.16	0.19	0.16	0.19	0.02	XXX
74235		C	Remove esophagus obstruction	0.00	0.00	0.00	NA	NA	0.00	XXX
74235	TC	C	Remove esophagus obstruction	0.00	0.00	0.00	NA	NA	0.00	XXX
74235	26	A	Remove esophagus obstruction	1.19	0.36	0.46	0.36	0.46	0.08	XXX
74240		A	X-ray exam, upper gi tract	0.69	2.04	2.16	NA	NA	0.04	XXX
74240	TC	A	X-ray exam, upper gi tract	0.00	1.83	1.91	NA	NA	0.01	XXX
74240	26	A	X-ray exam, upper gi tract	0.69	0.21	0.25	0.21	0.25	0.03	XXX
74241		A	X-ray exam, upper gi tract	0.69	2.27	2.36	NA	NA	0.03	XXX
74241	TC	A	X-ray exam, upper gi tract	0.00	2.06	2.12	NA	NA	0.01	XXX
74241	26	A	X-ray exam, upper gi tract	0.69	0.21	0.24	0.21	0.24	0.02	XXX
74245		A	X-ray exam, upper gi tract	0.91	3.45	3.65	NA	NA	0.05	XXX
74245	TC	A	X-ray exam, upper gi tract	0.00	3.18	3.32	NA	NA	0.01	XXX
74245	26	A	X-ray exam, upper gi tract	0.91	0.27	0.33	0.27	0.33	0.04	XXX

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74246		A	Contrst x-ray uppr gi tract	0.69	2.44	2.57	NA	NA	0.04	XXX
74246	TC	A	Contrst x-ray uppr gi tract	0.00	2.23	2.32	NA	NA	0.01	XXX
74246	26	A	Contrst x-ray uppr gi tract	0.69	0.21	0.25	0.21	0.25	0.03	XXX
74247		A	Contrst x-ray uppr gi tract	0.69	2.82	2.91	NA	NA	0.04	XXX
74247	TC	A	Contrst x-ray uppr gi tract	0.00	2.61	2.66	NA	NA	0.01	XXX
74247	26	A	Contrst x-ray uppr gi tract	0.69	0.21	0.25	0.21	0.25	0.03	XXX
74249		A	Contrst x-ray uppr gi tract	0.91	3.81	3.99	NA	NA	0.05	XXX
74249	TC	A	Contrst x-ray uppr gi tract	0.00	3.54	3.66	NA	NA	0.01	XXX
74249	26	A	Contrst x-ray uppr gi tract	0.91	0.27	0.33	0.27	0.33	0.04	XXX
74250		A	X-ray exam of small bowel	0.47	2.17	2.24	NA	NA	0.03	XXX
74250	TC	A	X-ray exam of small bowel	0.00	2.03	2.07	NA	NA	0.01	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.14	0.17	0.14	0.17	0.02	XXX
74251		A	X-ray exam of small bowel	0.69	8.84	8.21	NA	NA	0.04	XXX
74251	TC	A	X-ray exam of small bowel	0.00	8.63	7.96	NA	NA	0.01	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.21	0.25	0.21	0.25	0.03	XXX
74260		A	X-ray exam of small bowel	0.50	7.38	6.90	NA	NA	0.03	XXX
74260	TC	A	X-ray exam of small bowel	0.00	7.23	6.72	NA	NA	0.01	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.15	0.18	0.15	0.18	0.02	XXX
74261		A	Ct colonography, w/o dye	2.28	14.44	14.44	NA	NA	0.10	XXX
74261	TC	A	Ct colonography, w/o dye	0.00	13.75	13.75	NA	NA	0.01	XXX
74261	26	A	Ct colonography, w/o dye	2.28	0.69	0.69	0.69	0.69	0.09	XXX
74262		A	Ct colonography, w/dye	2.50	16.22	16.22	NA	NA	0.11	XXX
74262	TC	A	Ct colonography, w/dye	0.00	15.46	15.46	NA	NA	0.01	XXX
74262	26	A	Ct colonography, w/dye	2.50	0.76	0.76	0.76	0.76	0.10	XXX
74263		N	Ct colonography, screen	2.28	17.17	17.17	NA	NA	0.10	XXX
74263	TC	N	Ct colonography, screen	0.00	16.34	16.34	NA	NA	0.01	XXX
74263	26	N	Ct colonography, screen	2.28	0.83	0.83	0.83	0.83	0.09	XXX
74270		A	Contrast x-ray exam of colon	0.69	3.14	3.20	NA	NA	0.04	XXX
74270	TC	A	Contrast x-ray exam of colon	0.00	2.93	2.95	NA	NA	0.01	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.21	0.25	0.21	0.25	0.03	XXX
74280		A	Contrast x-ray exam of colon	0.99	4.34	4.41	NA	NA	0.05	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	4.04	4.05	NA	NA	0.01	XXX
74280	26	A	Contrast x-ray exam of colon	0.99	0.30	0.36	0.30	0.36	0.04	XXX
74283		A	Contrast x-ray exam of colon	2.02	3.14	3.42	NA	NA	0.05	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	2.51	2.70	NA	NA	0.01	XXX
74283	26	A	Contrast x-ray exam of colon	2.02	0.63	0.72	0.63	0.72	0.04	XXX
74290		A	Contrast x-ray, gallbladder	0.32	1.42	1.42	NA	NA	0.02	XXX
74290	TC	A	Contrast x-ray, gallbladder	0.00	1.32	1.30	NA	NA	0.01	XXX
74290	26	A	Contrast x-ray, gallbladder	0.32	0.10	0.12	0.10	0.12	0.01	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
74291		A	Contrast x-rays, gallbladder	0.20	1.48	1.36	NA	NA	0.02	XXX
74291	TC	A	Contrast x-rays, gallbladder	0.00	1.41	1.29	NA	NA	0.01	XXX
74291	26	A	Contrast x-rays, gallbladder	0.20	0.07	0.07	0.07	0.07	0.01	XXX
74300		C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74300	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74300	26	A	X-ray bile ducts/pancreas	0.36	0.11	0.13	0.11	0.13	0.03	XXX
74301		C	X-rays at surgery add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
74301	TC	C	X-rays at surgery add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
74301	26	A	X-rays at surgery add-on	0.21	0.07	0.08	0.07	0.08	0.02	ZZZ
74305		C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74305	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	NA	NA	0.00	XXX
74305	26	A	X-ray bile ducts/pancreas	0.42	0.12	0.15	0.12	0.15	0.03	XXX
74320		A	Contrast x-ray of bile ducts	0.54	1.90	2.34	NA	NA	0.03	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	1.74	2.14	NA	NA	0.01	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.16	0.20	0.16	0.20	0.02	XXX
74327		A	X-ray bile stone removal	0.70	2.63	2.76	NA	NA	0.10	XXX
74327	TC	A	X-ray bile stone removal	0.00	2.42	2.50	NA	NA	0.01	XXX
74327	26	A	X-ray bile stone removal	0.70	0.21	0.26	0.21	0.26	0.09	XXX
74328		C	X-ray bile duct endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74328	TC	C	X-ray bile duct endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74328	26	A	X-ray bile duct endoscopy	0.70	0.23	0.26	0.23	0.26	0.05	XXX
74329		C	X-ray for pancreas endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74329	TC	C	X-ray for pancreas endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74329	26	A	X-ray for pancreas endoscopy	0.70	0.23	0.26	0.23	0.26	0.04	XXX
74330		C	X-ray bile/panc endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74330	TC	C	X-ray bile/panc endoscopy	0.00	0.00	0.00	NA	NA	0.00	XXX
74330	26	A	X-ray bile/panc endoscopy	0.90	0.28	0.33	0.28	0.33	0.06	XXX
74340		C	X-ray guide for GI tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74340	TC	C	X-ray guide for GI tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74340	26	A	X-ray guide for GI tube	0.54	0.17	0.20	0.17	0.20	0.04	XXX
74355		C	X-ray guide, intestinal tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74355	TC	C	X-ray guide, intestinal tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74355	26	A	X-ray guide, intestinal tube	0.76	0.24	0.28	0.24	0.28	0.05	XXX
74360		C	X-ray guide, GI dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74360	TC	C	X-ray guide, GI dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74360	26	A	X-ray guide, GI dilation	0.54	0.22	0.23	0.22	0.23	0.04	XXX
74363		C	X-ray, bile duct dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74363	TC	C	X-ray, bile duct dilation	0.00	0.00	0.00	NA	NA	0.00	XXX
74363	26	A	X-ray, bile duct dilation	0.88	0.26	0.32	0.26	0.32	0.06	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
74400		A	Contrst x-ray, urinary tract	0.49	2.23	2.38	NA	NA	0.03	XXX
74400	TC	A	Contrst x-ray, urinary tract	0.00	2.08	2.21	NA	NA	0.01	XXX
74400	26	A	Contrst x-ray, urinary tract	0.49	0.15	0.17	0.15	0.17	0.02	XXX
74410		A	Contrst x-ray, urinary tract	0.49	2.25	2.51	NA	NA	0.03	XXX
74410	TC	A	Contrst x-ray, urinary tract	0.00	2.10	2.33	NA	NA	0.01	XXX
74410	26	A	Contrst x-ray, urinary tract	0.49	0.15	0.18	0.15	0.18	0.02	XXX
74415		A	Contrst x-ray, urinary tract	0.49	2.82	3.01	NA	NA	0.03	XXX
74415	TC	A	Contrst x-ray, urinary tract	0.00	2.67	2.83	NA	NA	0.01	XXX
74415	26	A	Contrst x-ray, urinary tract	0.49	0.15	0.18	0.15	0.18	0.02	XXX
74420		C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74420	TC	C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74420	26	A	Contrst x-ray, urinary tract	0.36	0.11	0.14	0.11	0.14	0.02	XXX
74425		C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74425	TC	C	Contrst x-ray, urinary tract	0.00	0.00	0.00	NA	NA	0.00	XXX
74425	26	A	Contrst x-ray, urinary tract	0.36	0.11	0.13	0.11	0.13	0.02	XXX
74430		A	Contrast x-ray, bladder	0.32	1.67	1.76	NA	NA	0.02	XXX
74430	TC	A	Contrast x-ray, bladder	0.00	1.57	1.64	NA	NA	0.01	XXX
74430	26	A	Contrast x-ray, bladder	0.32	0.10	0.12	0.10	0.12	0.01	XXX
74440		A	X-ray, male genital tract	0.38	1.73	1.85	NA	NA	0.03	XXX
74440	TC	A	X-ray, male genital tract	0.00	1.60	1.71	NA	NA	0.01	XXX
74440	26	A	X-ray, male genital tract	0.38	0.13	0.14	0.13	0.14	0.02	XXX
74445		C	X-ray exam of penis	0.00	0.00	0.00	NA	NA	0.00	XXX
74445	TC	C	X-ray exam of penis	0.00	0.00	0.00	NA	NA	0.00	XXX
74445	26	A	X-ray exam of penis	1.14	0.37	0.44	0.37	0.44	0.08	XXX
74450		C	X-ray, urethra/bladder	0.00	0.00	0.00	NA	NA	0.00	XXX
74450	TC	C	X-ray, urethra/bladder	0.00	0.00	0.00	NA	NA	0.00	XXX
74450	26	A	X-ray, urethra/bladder	0.33	0.10	0.13	0.10	0.13	0.02	XXX
74455		A	X-ray, urethra/bladder	0.33	1.78	2.02	NA	NA	0.02	XXX
74455	TC	A	X-ray, urethra/bladder	0.00	1.68	1.89	NA	NA	0.01	XXX
74455	26	A	X-ray, urethra/bladder	0.33	0.10	0.13	0.10	0.13	0.01	XXX
74470		C	X-ray exam of kidney lesion	0.00	0.00	0.00	NA	NA	0.00	XXX
74470	TC	C	X-ray exam of kidney lesion	0.00	0.00	0.00	NA	NA	0.00	XXX
74470	26	A	X-ray exam of kidney lesion	0.54	0.16	0.20	0.16	0.20	0.04	XXX
74475		A	X-ray control, cath insert	0.54	1.88	2.50	NA	NA	0.03	XXX
74475	TC	A	X-ray control, cath insert	0.00	1.72	2.30	NA	NA	0.01	XXX
74475	26	A	X-ray control, cath insert	0.54	0.16	0.20	0.16	0.20	0.02	XXX
74480		A	X-ray control, cath insert	0.54	1.88	2.51	NA	NA	0.03	XXX
74480	TC	A	X-ray control, cath insert	0.00	1.72	2.31	NA	NA	0.01	XXX
74480	26	A	X-ray control, cath insert	0.54	0.16	0.20	0.16	0.20	0.02	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
74485		A	X-ray guide, GU dilation	0.54	1.93	2.42	NA	NA	0.03	XXX
74485	TC	A	X-ray guide, GU dilation	0.00	1.76	2.22	NA	NA	0.01	XXX
74485	26	A	X-ray guide, GU dilation	0.54	0.17	0.20	0.17	0.20	0.02	XXX
74710		A	X-ray measurement of pelvis	0.34	0.56	0.75	NA	NA	0.02	XXX
74710	TC	A	X-ray measurement of pelvis	0.00	0.46	0.62	NA	NA	0.01	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.10	0.13	0.10	0.13	0.01	XXX
74740		A	X-ray, female genital tract	0.38	1.56	1.67	NA	NA	0.02	XXX
74740	TC	A	X-ray, female genital tract	0.00	1.44	1.53	NA	NA	0.01	XXX
74740	26	A	X-ray, female genital tract	0.38	0.12	0.14	0.12	0.14	0.01	XXX
74742		C	X-ray, fallopian tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74742	TC	C	X-ray, fallopian tube	0.00	0.00	0.00	NA	NA	0.00	XXX
74742	26	A	X-ray, fallopian tube	0.61	0.19	0.22	0.19	0.22	0.04	XXX
74775		C	X-ray exam of perineum	0.00	0.00	0.00	NA	NA	0.00	XXX
74775	TC	C	X-ray exam of perineum	0.00	0.00	0.00	NA	NA	0.00	XXX
74775	26	A	X-ray exam of perineum	0.62	0.19	0.22	0.19	0.22	0.04	XXX
75557		A	Cardiac mri for morph	2.35	5.84	9.90	NA	NA	0.08	XXX
75557	TC	A	Cardiac mri for morph	0.00	5.10	8.95	NA	NA	0.01	XXX
75557	26	A	Cardiac mri for morph	2.35	0.74	0.95	0.74	0.95	0.07	XXX
75559		A	Cardiac mri w/stress img	2.95	8.75	15.05	NA	NA	0.10	XXX
75559	TC	A	Cardiac mri w/stress img	0.00	7.81	13.78	NA	NA	0.01	XXX
75559	26	A	Cardiac mri w/stress img	2.95	0.94	1.27	0.94	1.27	0.09	XXX
75561		A	Cardiac mri for morph w/dye	2.60	8.23	14.01	NA	NA	0.09	XXX
75561	TC	A	Cardiac mri for morph w/dye	0.00	7.41	12.96	NA	NA	0.01	XXX
75561	26	A	Cardiac mri for morph w/dye	2.60	0.82	1.05	0.82	1.05	0.08	XXX
75563		A	Card mri w/stress img & dye	3.00	9.95	17.46	NA	NA	0.09	XXX
75563	TC	A	Card mri w/stress img & dye	0.00	8.98	16.12	NA	NA	0.01	XXX
75563	26	A	Card mri w/stress img & dye	3.00	0.97	1.34	0.97	1.34	0.08	XXX
75565		A	Card mri vel flw map add-on	0.25	2.27	2.27	NA	NA	0.02	XXX
75565	TC	A	Card mri vel flw map add-on	0.00	2.18	2.18	NA	NA	0.01	XXX
75565	26	A	Card mri vel flw map add-on	0.25	0.09	0.09	0.09	0.09	0.01	XXX
75571		A	Ct hrt w/o dye w/ca test	0.58	2.73	2.73	NA	NA	0.02	XXX
75571	TC	A	Ct hrt w/o dye w/ca test	0.00	2.55	2.55	NA	NA	0.01	XXX
75571	26	A	Ct hrt w/o dye w/ca test	0.58	0.18	0.18	0.18	0.18	0.01	XXX
75572		A	Ct hrt w/3d image	1.75	2.00	2.00	NA	NA	0.05	XXX
75572	TC	A	Ct hrt w/3d image	0.00	1.43	1.43	NA	NA	0.01	XXX
75572	26	A	Ct hrt w/3d image	1.75	0.57	0.57	0.57	0.57	0.04	XXX
75573		A	Ct hrt w/3d image, congen	2.55	2.48	2.48	NA	NA	0.07	XXX
75573	TC	A	Ct hrt w/3d image, congen	0.00	1.71	1.71	NA	NA	0.01	XXX
75573	26	A	Ct hrt w/3d image, congen	2.55	0.77	0.77	0.77	0.77	0.06	XXX

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75574		A	Ct angio hrt w/3d image	2.40	13.62	13.62	NA	NA	0.06	XXX
75574	TC	A	Ct angio hrt w/3d image	0.00	12.85	12.85	NA	NA	0.01	XXX
75574	26	A	Ct angio hrt w/3d image	2.40	0.77	0.77	0.77	0.77	0.05	XXX
75600		A	Contrast x-ray exam of aorta	0.49	4.79	7.16	NA	NA	0.03	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	4.63	6.94	NA	NA	0.01	XXX
75600	26	A	Contrast x-ray exam of aorta	0.49	0.16	0.22	0.16	0.22	0.02	XXX
75605		A	Contrast x-ray exam of aorta	1.14	2.75	5.15	NA	NA	0.06	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	2.39	4.69	NA	NA	0.01	XXX
75605	26	A	Contrast x-ray exam of aorta	1.14	0.36	0.46	0.36	0.46	0.05	XXX
75625		A	Contrast x-ray exam of aorta	1.14	2.83	5.09	NA	NA	0.08	XXX
75625	TC	A	Contrast x-ray exam of aorta	0.00	2.48	4.67	NA	NA	0.01	XXX
75625	26	A	Contrast x-ray exam of aorta	1.14	0.35	0.42	0.35	0.42	0.07	XXX
75630		A	X-ray aorta, leg arteries	1.79	3.04	5.51	NA	NA	0.08	XXX
75630	TC	A	X-ray aorta, leg arteries	0.00	2.47	4.82	NA	NA	0.01	XXX
75630	26	A	X-ray aorta, leg arteries	1.79	0.57	0.69	0.57	0.69	0.07	XXX
75635		A	Ct angio abdominal arteries	2.40	10.93	13.29	NA	NA	0.11	XXX
75635	TC	A	Ct angio abdominal arteries	0.00	10.20	12.38	NA	NA	0.02	XXX
75635	26	A	Ct angio abdominal arteries	2.40	0.73	0.91	0.73	0.91	0.09	XXX
75650		A	Artery x-rays, head & neck	1.49	2.94	5.26	NA	NA	0.08	XXX
75650	TC	A	Artery x-rays, head & neck	0.00	2.48	4.70	NA	NA	0.01	XXX
75650	26	A	Artery x-rays, head & neck	1.49	0.46	0.56	0.46	0.56	0.07	XXX
75658		A	Artery x-rays, arm	1.31	3.51	5.47	NA	NA	0.07	XXX
75658	TC	A	Artery x-rays, arm	0.00	3.11	5.02	NA	NA	0.01	XXX
75658	26	A	Artery x-rays, arm	1.31	0.40	0.45	0.40	0.45	0.06	XXX
75660		A	Artery x-rays, head & neck	1.31	3.46	5.57	NA	NA	0.04	XXX
75660	TC	A	Artery x-rays, head & neck	0.00	3.03	5.07	NA	NA	0.01	XXX
75660	26	A	Artery x-rays, head & neck	1.31	0.43	0.50	0.43	0.50	0.03	XXX
75662		A	Artery x-rays, head & neck	1.66	4.10	6.37	NA	NA	0.07	XXX
75662	TC	A	Artery x-rays, head & neck	0.00	3.55	5.70	NA	NA	0.02	XXX
75662	26	A	Artery x-rays, head & neck	1.66	0.55	0.67	0.55	0.67	0.05	XXX
75665		A	Artery x-rays, head & neck	1.31	3.67	5.77	NA	NA	0.10	XXX
75665	TC	A	Artery x-rays, head & neck	0.00	3.24	5.28	NA	NA	0.02	XXX
75665	26	A	Artery x-rays, head & neck	1.31	0.43	0.49	0.43	0.49	0.08	XXX
75671		A	Artery x-rays, head & neck	1.66	4.38	6.52	NA	NA	0.09	XXX
75671	TC	A	Artery x-rays, head & neck	0.00	3.85	5.89	NA	NA	0.02	XXX
75671	26	A	Artery x-rays, head & neck	1.66	0.53	0.63	0.53	0.63	0.07	XXX
75676		A	Artery x-rays, neck	1.31	3.39	5.55	NA	NA	0.09	XXX
75676	TC	A	Artery x-rays, neck	0.00	2.97	5.06	NA	NA	0.01	XXX
75676	26	A	Artery x-rays, neck	1.31	0.42	0.49	0.42	0.49	0.08	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
75680		A	Artery x-rays, neck	1.66	3.85	6.10	NA	NA	0.09	XXX
75680	TC	A	Artery x-rays, neck	0.00	3.32	5.46	NA	NA	0.02	XXX
75680	26	A	Artery x-rays, neck	1.66	0.53	0.64	0.53	0.64	0.07	XXX
75685		A	Artery x-rays, spine	1.31	3.43	5.58	NA	NA	0.07	XXX
75685	TC	A	Artery x-rays, spine	0.00	3.00	5.08	NA	NA	0.01	XXX
75685	26	A	Artery x-rays, spine	1.31	0.43	0.50	0.43	0.50	0.06	XXX
75705		A	Artery x-rays, spine	2.18	3.77	5.89	NA	NA	0.06	XXX
75705	TC	A	Artery x-rays, spine	0.00	3.07	5.07	NA	NA	0.01	XXX
75705	26	A	Artery x-rays, spine	2.18	0.70	0.82	0.70	0.82	0.05	XXX
75710		A	Artery x-rays, arm/leg	1.14	3.38	5.55	NA	NA	0.05	XXX
75710	TC	A	Artery x-rays, arm/leg	0.00	3.02	5.13	NA	NA	0.01	XXX
75710	26	A	Artery x-rays, arm/leg	1.14	0.36	0.42	0.36	0.42	0.04	XXX
75716		A	Artery x-rays, arms/legs	1.31	4.08	6.28	NA	NA	0.09	XXX
75716	TC	A	Artery x-rays, arms/legs	0.00	3.67	5.80	NA	NA	0.02	XXX
75716	26	A	Artery x-rays, arms/legs	1.31	0.41	0.48	0.41	0.48	0.07	XXX
75722		A	Artery x-rays, kidney	1.14	3.05	5.40	NA	NA	0.06	XXX
75722	TC	A	Artery x-rays, kidney	0.00	2.69	4.95	NA	NA	0.01	XXX
75722	26	A	Artery x-rays, kidney	1.14	0.36	0.45	0.36	0.45	0.05	XXX
75724		A	Artery x-rays, kidneys	1.49	3.63	6.26	NA	NA	0.06	XXX
75724	TC	A	Artery x-rays, kidneys	0.00	3.14	5.59	NA	NA	0.02	XXX
75724	26	A	Artery x-rays, kidneys	1.49	0.49	0.67	0.49	0.67	0.04	XXX
75726		A	Artery x-rays, abdomen	1.14	3.25	5.46	NA	NA	0.07	XXX
75726	TC	A	Artery x-rays, abdomen	0.00	2.91	5.04	NA	NA	0.01	XXX
75726	26	A	Artery x-rays, abdomen	1.14	0.34	0.42	0.34	0.42	0.06	XXX
75731		A	Artery x-rays, adrenal gland	1.14	3.05	5.61	NA	NA	0.04	XXX
75731	TC	A	Artery x-rays, adrenal gland	0.00	2.67	5.12	NA	NA	0.01	XXX
75731	26	A	Artery x-rays, adrenal gland	1.14	0.38	0.49	0.38	0.49	0.03	XXX
75733		A	Artery x-rays, adrenals	1.31	3.85	6.49	NA	NA	0.05	XXX
75733	TC	A	Artery x-rays, adrenals	0.00	3.41	5.90	NA	NA	0.02	XXX
75733	26	A	Artery x-rays, adrenals	1.31	0.44	0.59	0.44	0.59	0.03	XXX
75736		A	Artery x-rays, pelvis	1.14	3.22	5.50	NA	NA	0.05	XXX
75736	TC	A	Artery x-rays, pelvis	0.00	2.87	5.07	NA	NA	0.01	XXX
75736	26	A	Artery x-rays, pelvis	1.14	0.35	0.43	0.35	0.43	0.04	XXX
75741		A	Artery x-rays, lung	1.31	2.74	5.02	NA	NA	0.07	XXX
75741	TC	A	Artery x-rays, lung	0.00	2.35	4.53	NA	NA	0.01	XXX
75741	26	A	Artery x-rays, lung	1.31	0.39	0.49	0.39	0.49	0.06	XXX
75743		A	Artery x-rays, lungs	1.66	3.12	5.37	NA	NA	0.08	XXX
75743	TC	A	Artery x-rays, lungs	0.00	2.61	4.74	NA	NA	0.01	XXX
75743	26	A	Artery x-rays, lungs	1.66	0.51	0.63	0.51	0.63	0.07	XXX

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75746		A	Artery x-rays, lung	1.14	3.06	5.29	NA	NA	0.06	XXX
75746	TC	A	Artery x-rays, lung	0.00	2.71	4.87	NA	NA	0.01	XXX
75746	26	A	Artery x-rays, lung	1.14	0.35	0.42	0.35	0.42	0.05	XXX
75756		A	Artery x-rays, chest	1.14	3.23	5.69	NA	NA	0.16	XXX
75756	TC	A	Artery x-rays, chest	0.00	2.88	5.18	NA	NA	0.01	XXX
75756	26	A	Artery x-rays, chest	1.14	0.35	0.51	0.35	0.51	0.15	XXX
75774		A	Artery x-ray, each vessel	0.36	2.14	4.37	NA	NA	0.03	ZZZ
75774	TC	A	Artery x-ray, each vessel	0.00	2.03	4.24	NA	NA	0.01	ZZZ
75774	26	A	Artery x-ray, each vessel	0.36	0.11	0.13	0.11	0.13	0.02	ZZZ
75791		A	Av dialysis shunt imaging	1.71	6.69	6.69	NA	NA	0.08	XXX
75791	TC	A	Av dialysis shunt imaging	0.00	6.16	6.16	NA	NA	0.01	XXX
75791	26	A	Av dialysis shunt imaging	1.71	0.53	0.53	0.53	0.53	0.07	XXX
75801		C	Lymph vessel x-ray, arm/leg	0.00	0.00	0.00	NA	NA	0.00	XXX
75801	TC	C	Lymph vessel x-ray, arm/leg	0.00	0.00	0.00	NA	NA	0.00	XXX
75801	26	A	Lymph vessel x-ray, arm/leg	0.81	0.30	0.27	0.30	0.27	0.12	XXX
75803		C	Lymph vessel x-ray,arms/legs	0.00	0.00	0.00	NA	NA	0.00	XXX
75803	TC	C	Lymph vessel x-ray,arms/legs	0.00	0.00	0.00	NA	NA	0.00	XXX
75803	26	A	Lymph vessel x-ray,arms/legs	1.17	0.35	0.43	0.35	0.43	0.08	XXX
75805		C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75805	TC	C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75805	26	A	Lymph vessel x-ray, trunk	0.81	0.24	0.30	0.24	0.30	0.05	XXX
75807		C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75807	TC	C	Lymph vessel x-ray, trunk	0.00	0.00	0.00	NA	NA	0.00	XXX
75807	26	A	Lymph vessel x-ray, trunk	1.17	0.36	0.43	0.36	0.43	0.08	XXX
75809		A	Nonvascular shunt, x-ray	0.47	2.03	1.93	NA	NA	0.03	XXX
75809	TC	A	Nonvascular shunt, x-ray	0.00	1.88	1.76	NA	NA	0.01	XXX
75809	26	A	Nonvascular shunt, x-ray	0.47	0.15	0.17	0.15	0.17	0.02	XXX
75810		C	Vein x-ray, spleen/liver	0.00	0.00	0.00	NA	NA	0.00	XXX
75810	TC	C	Vein x-ray, spleen/liver	0.00	0.00	0.00	NA	NA	0.00	XXX
75810	26	A	Vein x-ray, spleen/liver	1.14	0.34	0.43	0.34	0.43	0.08	XXX
75820		A	Vein x-ray, arm/leg	0.70	2.48	2.53	NA	NA	0.04	XXX
75820	TC	A	Vein x-ray, arm/leg	0.00	2.26	2.26	NA	NA	0.01	XXX
75820	26	A	Vein x-ray, arm/leg	0.70	0.22	0.27	0.22	0.27	0.03	XXX
75822		A	Vein x-ray, arms/legs	1.06	2.85	2.88	NA	NA	0.06	XXX
75822	TC	A	Vein x-ray, arms/legs	0.00	2.53	2.50	NA	NA	0.01	XXX
75822	26	A	Vein x-ray, arms/legs	1.06	0.32	0.38	0.32	0.38	0.05	XXX
75825		A	Vein x-ray, trunk	1.14	2.65	4.84	NA	NA	0.07	XXX
75825	TC	A	Vein x-ray, trunk	0.00	2.31	4.44	NA	NA	0.01	XXX
75825	26	A	Vein x-ray, trunk	1.14	0.34	0.40	0.34	0.40	0.06	XXX

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75827		A	Vein x-ray, chest	1.14	2.80	4.87	NA	NA	0.06	XXX
75827	TC	A	Vein x-ray, chest	0.00	2.46	4.49	NA	NA	0.01	XXX
75827	26	A	Vein x-ray, chest	1.14	0.34	0.38	0.34	0.38	0.05	XXX
75831		A	Vein x-ray, kidney	1.14	2.76	4.94	NA	NA	0.18	XXX
75831	TC	A	Vein x-ray, kidney	0.00	2.43	4.53	NA	NA	0.01	XXX
75831	26	A	Vein x-ray, kidney	1.14	0.33	0.41	0.33	0.41	0.17	XXX
75833		A	Vein x-ray, kidneys	1.49	3.30	5.43	NA	NA	0.07	XXX
75833	TC	A	Vein x-ray, kidneys	0.00	2.87	4.92	NA	NA	0.01	XXX
75833	26	A	Vein x-ray, kidneys	1.49	0.43	0.51	0.43	0.51	0.06	XXX
75840		A	Vein x-ray, adrenal gland	1.14	2.60	4.84	NA	NA	0.18	XXX
75840	TC	A	Vein x-ray, adrenal gland	0.00	2.29	4.46	NA	NA	0.01	XXX
75840	26	A	Vein x-ray, adrenal gland	1.14	0.31	0.38	0.31	0.38	0.17	XXX
75842		A	Vein x-ray, adrenal glands	1.49	3.23	5.45	NA	NA	0.07	XXX
75842	TC	A	Vein x-ray, adrenal glands	0.00	2.77	4.91	NA	NA	0.01	XXX
75842	26	A	Vein x-ray, adrenal glands	1.49	0.46	0.54	0.46	0.54	0.06	XXX
75860		A	Vein x-ray, neck	1.14	2.72	5.04	NA	NA	0.07	XXX
75860	TC	A	Vein x-ray, neck	0.00	2.36	4.59	NA	NA	0.01	XXX
75860	26	A	Vein x-ray, neck	1.14	0.36	0.45	0.36	0.45	0.06	XXX
75870		A	Vein x-ray, skull	1.14	2.90	5.04	NA	NA	0.06	XXX
75870	TC	A	Vein x-ray, skull	0.00	2.52	4.62	NA	NA	0.01	XXX
75870	26	A	Vein x-ray, skull	1.14	0.38	0.42	0.38	0.42	0.05	XXX
75872		A	Vein x-ray, skull	1.14	5.87	6.25	NA	NA	0.06	XXX
75872	TC	A	Vein x-ray, skull	0.00	5.34	5.77	NA	NA	0.01	XXX
75872	26	A	Vein x-ray, skull	1.14	0.53	0.48	0.53	0.48	0.05	XXX
75880		A	Vein x-ray, eye socket	0.70	2.57	2.58	NA	NA	0.04	XXX
75880	TC	A	Vein x-ray, eye socket	0.00	2.35	2.34	NA	NA	0.01	XXX
75880	26	A	Vein x-ray, eye socket	0.70	0.22	0.24	0.22	0.24	0.03	XXX
75885		A	Vein x-ray, liver	1.44	2.79	5.07	NA	NA	0.07	XXX
75885	TC	A	Vein x-ray, liver	0.00	2.37	4.53	NA	NA	0.01	XXX
75885	26	A	Vein x-ray, liver	1.44	0.42	0.54	0.42	0.54	0.06	XXX
75887		A	Vein x-ray, liver	1.44	2.94	5.14	NA	NA	0.05	XXX
75887	TC	A	Vein x-ray, liver	0.00	2.49	4.60	NA	NA	0.01	XXX
75887	26	A	Vein x-ray, liver	1.44	0.45	0.54	0.45	0.54	0.04	XXX
75889		A	Vein x-ray, liver	1.14	2.72	4.94	NA	NA	0.06	XXX
75889	TC	A	Vein x-ray, liver	0.00	2.38	4.52	NA	NA	0.01	XXX
75889	26	A	Vein x-ray, liver	1.14	0.34	0.42	0.34	0.42	0.05	XXX
75891		A	Vein x-ray, liver	1.14	2.71	4.94	NA	NA	0.06	XXX
75891	TC	A	Vein x-ray, liver	0.00	2.38	4.52	NA	NA	0.01	XXX
75891	26	A	Vein x-ray, liver	1.14	0.33	0.42	0.33	0.42	0.05	XXX

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75893		A	Venous sampling by catheter	0.54	2.48	4.69	NA	NA	0.02	XXX
75893	TC	A	Venous sampling by catheter	0.00	2.32	4.50	NA	NA	0.01	XXX
75893	26	A	Venous sampling by catheter	0.54	0.16	0.19	0.16	0.19	0.01	XXX
75894		C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75894	TC	C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75894	26	A	X-rays, transcath therapy	1.31	0.40	0.47	0.40	0.47	0.12	XXX
75896		C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75896	TC	C	X-rays, transcath therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
75896	26	A	X-rays, transcath therapy	1.31	0.41	0.50	0.41	0.50	0.11	XXX
75898		C	Follow-up angiography	0.00	0.00	0.00	NA	NA	0.00	XXX
75898	TC	C	Follow-up angiography	0.00	0.00	0.00	NA	NA	0.00	XXX
75898	26	A	Follow-up angiography	1.65	0.51	0.63	0.51	0.63	0.14	XXX
75900		C	Intravascular cath exchange	0.00	0.00	0.00	NA	NA	0.00	XXX
75900	TC	C	Intravascular cath exchange	0.00	0.00	0.00	NA	NA	0.00	XXX
75900	26	A	Intravascular cath exchange	0.49	0.15	0.17	0.15	0.17	0.05	XXX
75901		A	Remove cva device obstruct	0.49	3.81	3.63	NA	NA	0.03	XXX
75901	TC	A	Remove cva device obstruct	0.00	3.66	3.45	NA	NA	0.01	XXX
75901	26	A	Remove cva device obstruct	0.49	0.15	0.18	0.15	0.18	0.02	XXX
75902		A	Remove cva lumen obstruct	0.39	1.52	1.59	NA	NA	0.04	XXX
75902	TC	A	Remove cva lumen obstruct	0.00	1.40	1.45	NA	NA	0.01	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.12	0.14	0.12	0.14	0.03	XXX
75940		C	X-ray placement, vein filter	0.00	0.00	0.00	NA	NA	0.00	XXX
75940	TC	C	X-ray placement, vein filter	0.00	0.00	0.00	NA	NA	0.00	XXX
75940	26	A	X-ray placement, vein filter	0.54	0.16	0.19	0.16	0.19	0.05	XXX
75945		C	Intravascular us	0.00	0.00	0.00	NA	NA	0.00	XXX
75945	TC	C	Intravascular us	0.00	0.00	0.00	NA	NA	0.00	XXX
75945	26	A	Intravascular us	0.40	0.12	0.15	0.12	0.15	0.05	XXX
75946		C	Intravascular us add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75946	TC	C	Intravascular us add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75946	26	A	Intravascular us add-on	0.40	0.12	0.13	0.12	0.13	0.06	ZZZ
75952		C	Endovasc repair abdom aorta	0.00	0.00	0.00	NA	NA	0.00	XXX
75952	TC	C	Endovasc repair abdom aorta	0.00	0.00	0.00	NA	NA	0.00	XXX
75952	26	A	Endovasc repair abdom aorta	4.49	1.34	1.42	1.34	1.42	0.63	XXX
75953		C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75953	TC	C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75953	26	A	Abdom aneurysm endovas rpr	1.36	0.41	0.43	0.41	0.43	0.19	XXX
75954		C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75954	TC	C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	NA	NA	0.00	XXX
75954	26	A	Iliac aneurysm endovas rpr	2.25	0.67	0.71	0.67	0.71	0.31	XXX

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75956		C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75956	TC	C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75956	26	A	Xray, endovasc thor ao repr	7.00	2.05	2.24	2.05	2.24	1.04	XXX
75957		C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75957	TC	C	Xray, endovasc thor ao repr	0.00	0.00	0.00	NA	NA	0.00	XXX
75957	26	A	Xray, endovasc thor ao repr	6.00	1.76	1.91	1.76	1.91	0.88	XXX
75958		C	Xray, place prox ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75958	TC	C	Xray, place prox ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75958	26	A	Xray, place prox ext thor ao	4.00	1.16	1.23	1.16	1.23	0.59	XXX
75959		C	Xray, place dist ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75959	TC	C	Xray, place dist ext thor ao	0.00	0.00	0.00	NA	NA	0.00	XXX
75959	26	A	Xray, place dist ext thor ao	3.50	0.95	1.08	0.95	1.08	0.60	XXX
75960		A	Transcath iv stent rs&i	0.82	2.27	5.00	NA	NA	0.05	XXX
75960	TC	A	Transcath iv stent rs&i	0.00	2.02	4.69	NA	NA	0.01	XXX
75960	26	A	Transcath iv stent rs&i	0.82	0.25	0.31	0.25	0.31	0.04	XXX
75961		A	Retrieval, broken catheter	4.24	4.06	6.04	NA	NA	0.18	XXX
75961	TC	A	Retrieval, broken catheter	0.00	2.79	4.51	NA	NA	0.01	XXX
75961	26	A	Retrieval, broken catheter	4.24	1.27	1.53	1.27	1.53	0.17	XXX
75962		A	Repair arterial blockage	0.54	2.99	5.75	NA	NA	0.03	XXX
75962	TC	A	Repair arterial blockage	0.00	2.82	5.55	NA	NA	0.01	XXX
75962	26	A	Repair arterial blockage	0.54	0.17	0.20	0.17	0.20	0.02	XXX
75964		A	Repair artery blockage, each	0.36	2.04	3.46	NA	NA	0.04	ZZZ
75964	TC	A	Repair artery blockage, each	0.00	1.93	3.33	NA	NA	0.01	ZZZ
75964	26	A	Repair artery blockage, each	0.36	0.11	0.13	0.11	0.13	0.03	ZZZ
75966		A	Repair arterial blockage	1.31	3.19	6.21	NA	NA	0.07	XXX
75966	TC	A	Repair arterial blockage	0.00	2.78	5.69	NA	NA	0.02	XXX
75966	26	A	Repair arterial blockage	1.31	0.41	0.52	0.41	0.52	0.05	XXX
75968		A	Repair artery blockage, each	0.36	1.89	3.43	NA	NA	0.02	ZZZ
75968	TC	A	Repair artery blockage, each	0.00	1.78	3.29	NA	NA	0.01	ZZZ
75968	26	A	Repair artery blockage, each	0.36	0.11	0.14	0.11	0.14	0.01	ZZZ
75970		C	Vascular biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
75970	TC	C	Vascular biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
75970	26	A	Vascular biopsy	0.83	0.25	0.31	0.25	0.31	0.06	XXX
75978		A	Repair venous blockage	0.54	3.11	5.69	NA	NA	0.03	XXX
75978	TC	A	Repair venous blockage	0.00	2.94	5.50	NA	NA	0.01	XXX
75978	26	A	Repair venous blockage	0.54	0.17	0.19	0.17	0.19	0.02	XXX
75980		C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75980	TC	C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75980	26	A	Contrast xray exam bile duct	1.44	0.42	0.53	0.42	0.53	0.10	XXX

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75982		C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75982	TC	C	Contrast xray exam bile duct	0.00	0.00	0.00	NA	NA	0.00	XXX
75982	26	A	Contrast xray exam bile duct	1.44	0.42	0.53	0.42	0.53	0.10	XXX
75984		A	Xray control catheter change	0.72	2.07	2.28	NA	NA	0.04	XXX
75984	TC	A	Xray control catheter change	0.00	1.86	2.01	NA	NA	0.01	XXX
75984	26	A	Xray control catheter change	0.72	0.21	0.27	0.21	0.27	0.03	XXX
75989		A	Abscess drainage under x-ray	1.19	2.00	2.48	NA	NA	0.05	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	1.64	2.05	NA	NA	0.01	XXX
75989	26	A	Abscess drainage under x-ray	1.19	0.36	0.43	0.36	0.43	0.04	XXX
75992		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75992	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75992	26	A	Atherectomy, x-ray exam	0.54	0.17	0.21	0.17	0.21	0.05	XXX
75993		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75993	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75993	26	A	Atherectomy, x-ray exam	0.36	0.11	0.14	0.11	0.14	0.04	ZZZ
75994		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75994	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75994	26	A	Atherectomy, x-ray exam	1.31	0.31	0.35	0.31	0.35	0.09	XXX
75995		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75995	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	XXX
75995	26	A	Atherectomy, x-ray exam	1.31	0.44	0.48	0.44	0.48	0.06	XXX
75996		C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75996	TC	C	Atherectomy, x-ray exam	0.00	0.00	0.00	NA	NA	0.00	ZZZ
75996	26	A	Atherectomy, x-ray exam	0.36	0.10	0.12	0.10	0.12	0.06	ZZZ
76000		A	Fluoroscope examination	0.17	2.66	2.50	NA	NA	0.02	XXX
76000	TC	A	Fluoroscope examination	0.00	2.60	2.44	NA	NA	0.01	XXX
76000	26	A	Fluoroscope examination	0.17	0.06	0.06	0.06	0.06	0.01	XXX
76001		C	Fluoroscope exam, extensive	0.00	0.00	0.00	NA	NA	0.00	XXX
76001	TC	C	Fluoroscope exam, extensive	0.00	0.00	0.00	NA	NA	0.00	XXX
76001	26	A	Fluoroscope exam, extensive	0.67	0.24	0.25	0.24	0.25	0.07	XXX
76010		A	X-ray, nose to rectum	0.18	0.46	0.55	NA	NA	0.02	XXX
76010	TC	A	X-ray, nose to rectum	0.00	0.41	0.48	NA	NA	0.01	XXX
76010	26	A	X-ray, nose to rectum	0.18	0.05	0.07	0.05	0.07	0.01	XXX
76080		A	X-ray exam of fistula	0.54	0.96	1.11	NA	NA	0.03	XXX
76080	TC	A	X-ray exam of fistula	0.00	0.80	0.91	NA	NA	0.01	XXX
76080	26	A	X-ray exam of fistula	0.54	0.16	0.20	0.16	0.20	0.02	XXX
76098		A	X-ray exam, breast specimen	0.16	0.28	0.35	NA	NA	0.02	XXX
76098	TC	A	X-ray exam, breast specimen	0.00	0.23	0.29	NA	NA	0.01	XXX
76098	26	A	X-ray exam, breast specimen	0.16	0.05	0.06	0.05	0.06	0.01	XXX

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76100		A	X-ray exam of body section	0.58	1.99	2.80	NA	NA	0.05	XXX
76100	TC	A	X-ray exam of body section	0.00	1.74	2.58	NA	NA	0.01	XXX
76100	26	A	X-ray exam of body section	0.58	0.25	0.22	0.25	0.22	0.04	XXX
76101		A	Complex body section x-ray	0.58	3.10	4.15	NA	NA	0.08	XXX
76101	TC	A	Complex body section x-ray	0.00	2.77	3.91	NA	NA	0.01	XXX
76101	26	A	Complex body section x-ray	0.58	0.33	0.24	0.33	0.24	0.07	XXX
76102		A	Complex body section x-rays	0.58	4.35	5.77	NA	NA	0.09	XXX
76102	TC	A	Complex body section x-rays	0.00	4.01	5.54	NA	NA	0.02	XXX
76102	26	A	Complex body section x-rays	0.58	0.34	0.23	0.34	0.23	0.07	XXX
76120		A	Cine/video x-rays	0.38	1.50	1.61	NA	NA	0.03	XXX
76120	TC	A	Cine/video x-rays	0.00	1.37	1.48	NA	NA	0.01	XXX
76120	26	A	Cine/video x-rays	0.38	0.13	0.13	0.13	0.13	0.02	XXX
76125		C	Cine/video x-rays add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
76125	TC	C	Cine/video x-rays add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
76125	26	A	Cine/video x-rays add-on	0.27	0.09	0.11	0.09	0.11	0.02	ZZZ
76140		I	X-ray consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76150		A	X-ray exam, dry process	0.00	0.55	0.51	NA	NA	0.01	XXX
76350		C	Special x-ray contrast study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76376		A	3d render w/o postprocess	0.20	1.23	1.78	NA	NA	0.02	XXX
76376	TC	A	3d render w/o postprocess	0.00	1.17	1.70	NA	NA	0.01	XXX
76376	26	A	3d render w/o postprocess	0.20	0.06	0.08	0.06	0.08	0.01	XXX
76377		A	3d rendering w/postprocess	0.79	1.20	1.81	NA	NA	0.04	XXX
76377	TC	A	3d rendering w/postprocess	0.00	0.96	1.53	NA	NA	0.01	XXX
76377	26	A	3d rendering w/postprocess	0.79	0.24	0.28	0.24	0.28	0.03	XXX
76380		A	CAT scan follow-up study	0.98	4.20	4.48	NA	NA	0.04	XXX
76380	TC	A	CAT scan follow-up study	0.00	3.89	4.13	NA	NA	0.01	XXX
76380	26	A	CAT scan follow-up study	0.98	0.31	0.35	0.31	0.35	0.03	XXX
76390		N	Mr spectroscopy	1.40	10.17	10.78	NA	NA	0.04	XXX
76390	TC	N	Mr spectroscopy	0.00	9.66	10.29	NA	NA	0.01	XXX
76390	26	N	Mr spectroscopy	1.40	0.51	0.49	0.51	0.49	0.03	XXX
76496		C	Fluoroscopic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76496	TC	C	Fluoroscopic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76496	26	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497		C	Ct procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76497	TC	C	Ct procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76497	26	C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76498		C	Mri procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76498	TC	C	Mri procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76498	26	C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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76499		C	Radiographic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76499	TC	C	Radiographic procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76499	26	C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76506		A	Echo exam of head	0.63	2.49	2.49	NA	NA	0.04	XXX
76506	TC	A	Echo exam of head	0.00	2.28	2.26	NA	NA	0.01	XXX
76506	26	A	Echo exam of head	0.63	0.21	0.23	0.21	0.23	0.03	XXX
76510		A	Ophth us, b & quant a	1.55	2.77	2.56	NA	NA	0.19	XXX
76510	TC	A	Ophth us, b & quant a	0.00	1.86	1.85	NA	NA	0.01	XXX
76510	26	A	Ophth us, b & quant a	1.55	0.91	0.71	0.91	0.71	0.18	XXX
76511		A	Ophth us, quant a only	0.94	1.63	1.65	NA	NA	0.02	XXX
76511	TC	A	Ophth us, quant a only	0.00	1.11	1.24	NA	NA	0.01	XXX
76511	26	A	Ophth us, quant a only	0.94	0.52	0.41	0.52	0.41	0.01	XXX
76512		A	Ophth us, b w/non-quant a	0.94	1.44	1.48	NA	NA	0.04	XXX
76512	TC	A	Ophth us, b w/non-quant a	0.00	0.91	1.05	NA	NA	0.01	XXX
76512	26	A	Ophth us, b w/non-quant a	0.94	0.53	0.43	0.53	0.43	0.03	XXX
76513		A	Echo exam of eye, water bath	0.66	1.67	1.60	NA	NA	0.02	XXX
76513	TC	A	Echo exam of eye, water bath	0.00	1.35	1.34	NA	NA	0.01	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.32	0.26	0.32	0.26	0.01	XXX
76514		A	Echo exam of eye, thickness	0.17	0.21	0.18	NA	NA	0.02	XXX
76514	TC	A	Echo exam of eye, thickness	0.00	0.12	0.10	NA	NA	0.01	XXX
76514	26	A	Echo exam of eye, thickness	0.17	0.09	0.08	0.09	0.08	0.01	XXX
76516		A	Echo exam of eye	0.54	1.37	1.29	NA	NA	0.02	XXX
76516	TC	A	Echo exam of eye	0.00	1.07	1.05	NA	NA	0.01	XXX
76516	26	A	Echo exam of eye	0.54	0.30	0.24	0.30	0.24	0.01	XXX
76519		A	Echo exam of eye	0.54	1.51	1.42	NA	NA	0.02	XXX
76519	TC	A	Echo exam of eye	0.00	1.20	1.17	NA	NA	0.01	XXX
76519	26	A	Echo exam of eye	0.54	0.31	0.25	0.31	0.25	0.01	XXX
76529		A	Echo exam of eye	0.57	1.40	1.27	NA	NA	0.03	XXX
76529	TC	A	Echo exam of eye	0.00	1.06	1.02	NA	NA	0.01	XXX
76529	26	A	Echo exam of eye	0.57	0.34	0.25	0.34	0.25	0.02	XXX
76536		A	Us exam of head and neck	0.56	2.43	2.43	NA	NA	0.03	XXX
76536	TC	A	Us exam of head and neck	0.00	2.25	2.24	NA	NA	0.01	XXX
76536	26	A	Us exam of head and neck	0.56	0.18	0.19	0.18	0.19	0.02	XXX
76604		A	Us exam, chest	0.55	1.60	1.73	NA	NA	0.03	XXX
76604	TC	A	Us exam, chest	0.00	1.44	1.54	NA	NA	0.01	XXX
76604	26	A	Us exam, chest	0.55	0.16	0.19	0.16	0.19	0.02	XXX
76645		A	Us exam, breast(s)	0.54	1.85	1.91	NA	NA	0.04	XXX
76645	TC	A	Us exam, breast(s)	0.00	1.69	1.72	NA	NA	0.01	XXX
76645	26	A	Us exam, breast(s)	0.54	0.16	0.19	0.16	0.19	0.03	XXX

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76700		A	Us exam, abdom, complete	0.81	2.67	2.83	NA	NA	0.04	XXX
76700	TC	A	Us exam, abdom, complete	0.00	2.42	2.54	NA	NA	0.01	XXX
76700	26	A	Us exam, abdom, complete	0.81	0.25	0.29	0.25	0.29	0.03	XXX
76705		A	Echo exam of abdomen	0.59	2.05	2.17	NA	NA	0.03	XXX
76705	TC	A	Echo exam of abdomen	0.00	1.87	1.96	NA	NA	0.01	XXX
76705	26	A	Echo exam of abdomen	0.59	0.18	0.21	0.18	0.21	0.02	XXX
76770		A	Us exam abdo back wall, comp	0.74	2.54	2.72	NA	NA	0.04	XXX
76770	TC	A	Us exam abdo back wall, comp	0.00	2.31	2.46	NA	NA	0.01	XXX
76770	26	A	Us exam abdo back wall, comp	0.74	0.23	0.26	0.23	0.26	0.03	XXX
76775		A	Us exam abdo back wall, lim	0.58	2.07	2.35	NA	NA	0.03	XXX
76775	TC	A	Us exam abdo back wall, lim	0.00	1.89	2.13	NA	NA	0.01	XXX
76775	26	A	Us exam abdo back wall, lim	0.58	0.18	0.22	0.18	0.22	0.02	XXX
76776		A	Us exam k transpl w/doppler	0.76	2.98	3.13	NA	NA	0.04	XXX
76776	TC	A	Us exam k transpl w/doppler	0.00	2.75	2.86	NA	NA	0.01	XXX
76776	26	A	Us exam k transpl w/doppler	0.76	0.23	0.27	0.23	0.27	0.03	XXX
76800		A	Us exam, spinal canal	1.13	2.37	2.23	NA	NA	0.04	XXX
76800	TC	A	Us exam, spinal canal	0.00	1.97	1.88	NA	NA	0.01	XXX
76800	26	A	Us exam, spinal canal	1.13	0.40	0.35	0.40	0.35	0.03	XXX
76801		A	Ob us < 14 wks, single fetus	0.99	2.21	2.44	NA	NA	0.03	XXX
76801	TC	A	Ob us < 14 wks, single fetus	0.00	1.88	2.09	NA	NA	0.01	XXX
76801	26	A	Ob us < 14 wks, single fetus	0.99	0.33	0.35	0.33	0.35	0.02	XXX
76802		A	Ob us < 14 wks, addl fetus	0.83	0.92	1.05	NA	NA	0.03	ZZZ
76802	TC	A	Ob us < 14 wks, addl fetus	0.00	0.63	0.76	NA	NA	0.01	ZZZ
76802	26	A	Ob us < 14 wks, addl fetus	0.83	0.29	0.29	0.29	0.29	0.02	ZZZ
76805		A	Ob us >/= 14 wks, sngl fetus	0.99	2.73	2.89	NA	NA	0.03	XXX
76805	TC	A	Ob us >/= 14 wks, sngl fetus	0.00	2.39	2.54	NA	NA	0.01	XXX
76805	26	A	Ob us >/= 14 wks, sngl fetus	0.99	0.34	0.35	0.34	0.35	0.02	XXX
76810		A	Ob us >/= 14 wks, addl fetus	0.98	1.53	1.59	NA	NA	0.03	ZZZ
76810	TC	A	Ob us >/= 14 wks, addl fetus	0.00	1.19	1.25	NA	NA	0.01	ZZZ
76810	26	A	Ob us >/= 14 wks, addl fetus	0.98	0.34	0.34	0.34	0.34	0.02	ZZZ
76811		A	Ob us, detailed, sngl fetus	1.90	2.90	3.28	NA	NA	0.05	XXX
76811	TC	A	Ob us, detailed, sngl fetus	0.00	2.19	2.63	NA	NA	0.01	XXX
76811	26	A	Ob us, detailed, sngl fetus	1.90	0.71	0.65	0.71	0.65	0.04	XXX
76812		A	Ob us, detailed, addl fetus	1.78	3.68	3.50	NA	NA	0.04	ZZZ
76812	TC	A	Ob us, detailed, addl fetus	0.00	3.01	2.89	NA	NA	0.01	ZZZ
76812	26	A	Ob us, detailed, addl fetus	1.78	0.67	0.61	0.67	0.61	0.03	ZZZ
76813		A	Ob us nuchal meas, 1 gest	1.18	2.05	2.18	NA	NA	0.03	XXX
76813	TC	A	Ob us nuchal meas, 1 gest	0.00	1.61	1.79	NA	NA	0.01	XXX
76813	26	A	Ob us nuchal meas, 1 gest	1.18	0.44	0.39	0.44	0.39	0.02	XXX

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76814		A	Ob us nuchal meas, add-on	0.99	1.14	1.16	NA	NA	0.03	XXX
76814	TC	A	Ob us nuchal meas, add-on	0.00	0.76	0.83	NA	NA	0.01	XXX
76814	26	A	Ob us nuchal meas, add-on	0.99	0.38	0.33	0.38	0.33	0.02	XXX
76815		A	Ob us, limited, fetus(s)	0.65	1.62	1.74	NA	NA	0.02	XXX
76815	TC	A	Ob us, limited, fetus(s)	0.00	1.40	1.52	NA	NA	0.01	XXX
76815	26	A	Ob us, limited, fetus(s)	0.65	0.22	0.22	0.22	0.22	0.01	XXX
76816		A	Ob us, follow-up, per fetus	0.85	2.17	2.16	NA	NA	0.03	XXX
76816	TC	A	Ob us, follow-up, per fetus	0.00	1.86	1.87	NA	NA	0.01	XXX
76816	26	A	Ob us, follow-up, per fetus	0.85	0.31	0.29	0.31	0.29	0.02	XXX
76817		A	Transvaginal us, obstetric	0.75	1.82	1.95	NA	NA	0.02	XXX
76817	TC	A	Transvaginal us, obstetric	0.00	1.56	1.69	NA	NA	0.01	XXX
76817	26	A	Transvaginal us, obstetric	0.75	0.26	0.26	0.26	0.26	0.01	XXX
76818		A	Fetal biophys profile w/nst	1.05	2.06	2.16	NA	NA	0.03	XXX
76818	TC	A	Fetal biophys profile w/nst	0.00	1.67	1.80	NA	NA	0.01	XXX
76818	26	A	Fetal biophys profile w/nst	1.05	0.39	0.36	0.39	0.36	0.02	XXX
76819		A	Fetal biophys profil w/o nst	0.77	1.48	1.67	NA	NA	0.02	XXX
76819	TC	A	Fetal biophys profil w/o nst	0.00	1.21	1.40	NA	NA	0.01	XXX
76819	26	A	Fetal biophys profil w/o nst	0.77	0.27	0.27	0.27	0.27	0.01	XXX
76820		A	Umbilical artery echo	0.50	0.56	0.81	NA	NA	0.02	XXX
76820	TC	A	Umbilical artery echo	0.00	0.37	0.64	NA	NA	0.01	XXX
76820	26	A	Umbilical artery echo	0.50	0.19	0.17	0.19	0.17	0.01	XXX
76821		A	Middle cerebral artery echo	0.70	1.71	1.84	NA	NA	0.02	XXX
76821	TC	A	Middle cerebral artery echo	0.00	1.45	1.60	NA	NA	0.01	XXX
76821	26	A	Middle cerebral artery echo	0.70	0.26	0.24	0.26	0.24	0.01	XXX
76825		A	Echo exam of fetal heart	1.67	3.95	3.97	NA	NA	0.04	XXX
76825	TC	A	Echo exam of fetal heart	0.00	3.34	3.40	NA	NA	0.01	XXX
76825	26	A	Echo exam of fetal heart	1.67	0.61	0.57	0.61	0.57	0.03	XXX
76826		A	Echo exam of fetal heart	0.83	2.48	2.35	NA	NA	0.03	XXX
76826	TC	A	Echo exam of fetal heart	0.00	2.18	2.07	NA	NA	0.01	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.30	0.28	0.30	0.28	0.02	XXX
76827		A	Echo exam of fetal heart	0.58	1.00	1.23	NA	NA	0.02	XXX
76827	TC	A	Echo exam of fetal heart	0.00	0.79	1.03	NA	NA	0.01	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.21	0.20	0.21	0.20	0.01	XXX
76828		A	Echo exam of fetal heart	0.56	0.63	0.78	NA	NA	0.02	XXX
76828	TC	A	Echo exam of fetal heart	0.00	0.42	0.59	NA	NA	0.01	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.21	0.19	0.21	0.19	0.01	XXX
76830		A	Transvaginal us, non-ob	0.69	2.44	2.52	NA	NA	0.03	XXX
76830	TC	A	Transvaginal us, non-ob	0.00	2.21	2.28	NA	NA	0.01	XXX
76830	26	A	Transvaginal us, non-ob	0.69	0.23	0.24	0.23	0.24	0.02	XXX

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76831		A	Echo exam, uterus	0.72	2.47	2.50	NA	NA	0.03	XXX
76831	TC	A	Echo exam, uterus	0.00	2.20	2.26	NA	NA	0.01	XXX
76831	26	A	Echo exam, uterus	0.72	0.27	0.24	0.27	0.24	0.02	XXX
76856		A	Us exam, pelvic, complete	0.69	2.41	2.53	NA	NA	0.03	XXX
76856	TC	A	Us exam, pelvic, complete	0.00	2.19	2.28	NA	NA	0.01	XXX
76856	26	A	Us exam, pelvic, complete	0.69	0.22	0.25	0.22	0.25	0.02	XXX
76857		A	Us exam, pelvic, limited	0.38	1.99	2.27	NA	NA	0.03	XXX
76857	TC	A	Us exam, pelvic, limited	0.00	1.87	2.12	NA	NA	0.01	XXX
76857	26	A	Us exam, pelvic, limited	0.38	0.12	0.15	0.12	0.15	0.02	XXX
76870		A	Us exam, scrotum	0.64	2.42	2.54	NA	NA	0.04	XXX
76870	TC	A	Us exam, scrotum	0.00	2.22	2.31	NA	NA	0.01	XXX
76870	26	A	Us exam, scrotum	0.64	0.20	0.23	0.20	0.23	0.03	XXX
76872		A	Us, transrectal	0.69	2.61	3.03	NA	NA	0.04	XXX
76872	TC	A	Us, transrectal	0.00	2.38	2.76	NA	NA	0.01	XXX
76872	26	A	Us, transrectal	0.69	0.23	0.27	0.23	0.27	0.03	XXX
76873		A	Echograp trans r, pros study	1.55	3.02	3.18	NA	NA	0.07	XXX
76873	TC	A	Echograp trans r, pros study	0.00	2.43	2.60	NA	NA	0.01	XXX
76873	26	A	Echograp trans r, pros study	1.55	0.59	0.58	0.59	0.58	0.06	XXX
76880		A	Us exam, extremity	0.59	2.98	2.85	NA	NA	0.03	XXX
76880	TC	A	Us exam, extremity	0.00	2.80	2.66	NA	NA	0.01	XXX
76880	26	A	Us exam, extremity	0.59	0.18	0.19	0.18	0.19	0.02	XXX
76885		A	Us exam infant hips, dynamic	0.74	2.90	2.93	NA	NA	0.04	XXX
76885	TC	A	Us exam infant hips, dynamic	0.00	2.67	2.67	NA	NA	0.01	XXX
76885	26	A	Us exam infant hips, dynamic	0.74	0.23	0.26	0.23	0.26	0.03	XXX
76886		A	Us exam infant hips, static	0.62	2.54	2.20	NA	NA	0.02	XXX
76886	TC	A	Us exam infant hips, static	0.00	2.30	1.98	NA	NA	0.01	XXX
76886	26	A	Us exam infant hips, static	0.62	0.24	0.22	0.24	0.22	0.01	XXX
76930		A	Echo guide, cardiocentesis	0.67	1.40	1.83	NA	NA	0.03	XXX
76930	TC	A	Echo guide, cardiocentesis	0.00	1.18	1.53	NA	NA	0.02	XXX
76930	26	A	Echo guide, cardiocentesis	0.67	0.22	0.30	0.22	0.30	0.01	XXX
76932		C	Echo guide for heart biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
76932	TC	C	Echo guide for heart biopsy	0.00	0.00	0.00	NA	NA	0.00	XXX
76932	26	A	Echo guide for heart biopsy	0.67	0.22	0.30	0.22	0.30	0.04	XXX
76936		A	Echo guide for artery repair	1.99	5.35	6.13	NA	NA	0.17	XXX
76936	TC	A	Echo guide for artery repair	0.00	4.74	5.42	NA	NA	0.02	XXX
76936	26	A	Echo guide for artery repair	1.99	0.61	0.71	0.61	0.71	0.15	XXX
76937		A	Us guide, vascular access	0.30	0.57	0.60	NA	NA	0.03	ZZZ
76937	TC	A	Us guide, vascular access	0.00	0.48	0.49	NA	NA	0.01	ZZZ
76937	26	A	Us guide, vascular access	0.30	0.09	0.11	0.09	0.11	0.02	ZZZ

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76940		C	Us guide, tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
76940	TC	C	Us guide, tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
76940	26	A	Us guide, tissue ablation	2.00	0.66	0.69	0.66	0.69	0.20	XXX
76941		C	Echo guide for transfusion	0.00	0.00	0.00	NA	NA	0.00	XXX
76941	TC	C	Echo guide for transfusion	0.00	0.00	0.00	NA	NA	0.00	XXX
76941	26	A	Echo guide for transfusion	1.34	0.52	0.47	0.52	0.47	0.09	XXX
76942		A	Echo guide for biopsy	0.67	4.17	4.33	NA	NA	0.04	XXX
76942	TC	A	Echo guide for biopsy	0.00	3.96	4.09	NA	NA	0.01	XXX
76942	26	A	Echo guide for biopsy	0.67	0.21	0.24	0.21	0.24	0.03	XXX
76945		C	Echo guide, villus sampling	0.00	0.00	0.00	NA	NA	0.00	XXX
76945	TC	C	Echo guide, villus sampling	0.00	0.00	0.00	NA	NA	0.00	XXX
76945	26	A	Echo guide, villus sampling	0.67	0.26	0.23	0.26	0.23	0.03	XXX
76946		A	Echo guide for amniocentesis	0.38	0.44	0.69	NA	NA	0.02	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	0.30	0.56	NA	NA	0.01	XXX
76946	26	A	Echo guide for amniocentesis	0.38	0.14	0.13	0.14	0.13	0.01	XXX
76948		A	Echo guide, ova aspiration	0.38	0.52	0.71	NA	NA	0.03	XXX
76948	TC	A	Echo guide, ova aspiration	0.00	0.38	0.58	NA	NA	0.01	XXX
76948	26	A	Echo guide, ova aspiration	0.38	0.14	0.13	0.14	0.13	0.02	XXX
76950		A	Echo guidance radiotherapy	0.58	1.17	1.27	NA	NA	0.03	XXX
76950	TC	A	Echo guidance radiotherapy	0.00	0.93	1.06	NA	NA	0.01	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.24	0.21	0.24	0.21	0.02	XXX
76965		A	Echo guidance radiotherapy	1.34	1.05	2.11	NA	NA	0.07	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	0.56	1.60	NA	NA	0.01	XXX
76965	26	A	Echo guidance radiotherapy	1.34	0.49	0.51	0.49	0.51	0.06	XXX
76970		A	Ultrasound exam follow-up	0.40	2.22	1.95	NA	NA	0.04	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	2.07	1.82	NA	NA	0.01	XXX
76970	26	A	Ultrasound exam follow-up	0.40	0.15	0.13	0.15	0.13	0.03	XXX
76975		C	GI endoscopic ultrasound	0.00	0.00	0.00	NA	NA	0.00	XXX
76975	TC	C	GI endoscopic ultrasound	0.00	0.00	0.00	NA	NA	0.00	XXX
76975	26	A	GI endoscopic ultrasound	0.81	0.31	0.32	0.31	0.32	0.06	XXX
76977		A	Us bone density measure	0.05	0.12	0.25	NA	NA	0.02	XXX
76977	TC	A	Us bone density measure	0.00	0.10	0.23	NA	NA	0.01	XXX
76977	26	A	Us bone density measure	0.05	0.02	0.02	0.02	0.02	0.01	XXX
76998		C	Us guide, intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
76998	TC	C	Us guide, intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
76998	26	A	Us guide, intraop	1.20	0.40	0.40	0.40	0.40	0.18	XXX
76999		C	Echo examination procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76999	TC	C	Echo examination procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
76999	26	C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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77001		A	Fluoroguide for vein device	0.38	2.56	2.48	NA	NA	0.02	ZZZ
77001	TC	A	Fluoroguide for vein device	0.00	2.44	2.34	NA	NA	0.01	ZZZ
77001	26	A	Fluoroguide for vein device	0.38	0.12	0.14	0.12	0.14	0.01	ZZZ
77002		A	Needle localization by xray	0.54	1.36	1.36	NA	NA	0.03	XXX
77002	TC	A	Needle localization by xray	0.00	1.16	1.17	NA	NA	0.01	XXX
77002	26	A	Needle localization by xray	0.54	0.20	0.19	0.20	0.19	0.02	XXX
77003		A	Fluoroguide for spine inject	0.60	1.03	0.97	NA	NA	0.03	XXX
77003	TC	A	Fluoroguide for spine inject	0.00	0.80	0.80	NA	NA	0.01	XXX
77003	26	A	Fluoroguide for spine inject	0.60	0.23	0.17	0.23	0.17	0.02	XXX
77011		A	Ct scan for localization	1.21	18.45	17.67	NA	NA	0.04	XXX
77011	TC	A	Ct scan for localization	0.00	18.00	17.23	NA	NA	0.01	XXX
77011	26	A	Ct scan for localization	1.21	0.45	0.44	0.45	0.44	0.03	XXX
77012		A	Ct scan for needle biopsy	1.16	2.06	3.52	NA	NA	0.04	XXX
77012	TC	A	Ct scan for needle biopsy	0.00	1.71	3.10	NA	NA	0.01	XXX
77012	26	A	Ct scan for needle biopsy	1.16	0.35	0.42	0.35	0.42	0.03	XXX
77013		C	Ct guide for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77013	TC	C	Ct guide for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77013	26	A	Ct guide for tissue ablation	3.99	1.18	1.46	1.18	1.46	0.27	XXX
77014		A	Ct scan for therapy guide	0.85	4.10	4.15	NA	NA	0.04	XXX
77014	TC	A	Ct scan for therapy guide	0.00	3.75	3.84	NA	NA	0.01	XXX
77014	26	A	Ct scan for therapy guide	0.85	0.35	0.31	0.35	0.31	0.03	XXX
77021		A	Mr guidance for needle place	1.50	8.38	9.97	NA	NA	0.10	XXX
77021	TC	A	Mr guidance for needle place	0.00	7.92	9.43	NA	NA	0.01	XXX
77021	26	A	Mr guidance for needle place	1.50	0.46	0.54	0.46	0.54	0.09	XXX
77022		C	Mri for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77022	TC	C	Mri for tissue ablation	0.00	0.00	0.00	NA	NA	0.00	XXX
77022	26	A	Mri for tissue ablation	4.24	1.27	1.46	1.27	1.46	0.28	XXX
77031		A	Stereotact guide for brst bx	1.59	1.70	2.98	NA	NA	0.10	XXX
77031	TC	A	Stereotact guide for brst bx	0.00	1.20	2.42	NA	NA	0.01	XXX
77031	26	A	Stereotact guide for brst bx	1.59	0.50	0.56	0.50	0.56	0.09	XXX
77032		A	Guidance for needle, breast	0.56	0.73	0.95	NA	NA	0.03	XXX
77032	TC	A	Guidance for needle, breast	0.00	0.56	0.75	NA	NA	0.01	XXX
77032	26	A	Guidance for needle, breast	0.56	0.17	0.20	0.17	0.20	0.02	XXX
77051		A	Computer dx mammogram add-on	0.06	0.17	0.24	NA	NA	0.02	ZZZ
77051	TC	A	Computer dx mammogram add-on	0.00	0.15	0.22	NA	NA	0.01	ZZZ
77051	26	A	Computer dx mammogram add-on	0.06	0.02	0.02	0.02	0.02	0.01	ZZZ

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77052		A	Comp screen mammogram add-on	0.06	0.17	0.24	NA	NA	0.02	ZZZ
77052	TC	A	Comp screen mammogram add-on	0.00	0.15	0.22	NA	NA	0.01	ZZZ
77052	26	A	Comp screen mammogram add-on	0.06	0.02	0.02	0.02	0.02	0.01	ZZZ
77053		A	X-ray of mammary duct	0.36	1.07	1.50	NA	NA	0.02	XXX
77053	TC	A	X-ray of mammary duct	0.00	0.96	1.37	NA	NA	0.01	XXX
77053	26	A	X-ray of mammary duct	0.36	0.11	0.13	0.11	0.13	0.01	XXX
77054		A	X-ray of mammary ducts	0.45	1.46	2.05	NA	NA	0.03	XXX
77054	TC	A	X-ray of mammary ducts	0.00	1.32	1.89	NA	NA	0.01	XXX
77054	26	A	X-ray of mammary ducts	0.45	0.14	0.16	0.14	0.16	0.02	XXX
77055		A	Mammogram, one breast	0.70	1.42	1.55	NA	NA	0.04	XXX
77055	TC	A	Mammogram, one breast	0.00	1.21	1.30	NA	NA	0.01	XXX
77055	26	A	Mammogram, one breast	0.70	0.21	0.25	0.21	0.25	0.03	XXX
77056		A	Mammogram, both breasts	0.87	1.86	2.00	NA	NA	0.05	XXX
77056	TC	A	Mammogram, both breasts	0.00	1.60	1.69	NA	NA	0.01	XXX
77056	26	A	Mammogram, both breasts	0.87	0.26	0.31	0.26	0.31	0.04	XXX
77057		A	Mammogram, screening	0.70	1.26	1.43	NA	NA	0.04	XXX
77057	TC	A	Mammogram, screening	0.00	1.05	1.18	NA	NA	0.01	XXX
77057	26	A	Mammogram, screening	0.70	0.21	0.25	0.21	0.25	0.03	XXX
77058		A	Mri, one breast	1.63	11.36	18.65	NA	NA	0.09	XXX
77058	TC	A	Mri, one breast	0.00	10.87	18.07	NA	NA	0.02	XXX
77058	26	A	Mri, one breast	1.63	0.49	0.58	0.49	0.58	0.07	XXX
77059		A	Mri, both breasts	1.63	11.25	19.75	NA	NA	0.09	XXX
77059	TC	A	Mri, both breasts	0.00	10.76	19.17	NA	NA	0.02	XXX
77059	26	A	Mri, both breasts	1.63	0.49	0.58	0.49	0.58	0.07	XXX
77071		A	X-ray stress view	0.41	0.85	0.69	0.85	0.69	0.05	XXX
77072		A	X-rays for bone age	0.19	0.38	0.42	NA	NA	0.02	XXX
77072	TC	A	X-rays for bone age	0.00	0.32	0.35	NA	NA	0.01	XXX
77072	26	A	X-rays for bone age	0.19	0.06	0.07	0.06	0.07	0.01	XXX
77073		A	X-rays, bone length studies	0.27	0.68	0.71	NA	NA	0.04	XXX
77073	TC	A	X-rays, bone length studies	0.00	0.57	0.61	NA	NA	0.01	XXX
77073	26	A	X-rays, bone length studies	0.27	0.11	0.10	0.11	0.10	0.03	XXX
77074		A	X-rays, bone survey, limited	0.45	1.25	1.36	NA	NA	0.03	XXX
77074	TC	A	X-rays, bone survey, limited	0.00	1.11	1.20	NA	NA	0.01	XXX
77074	26	A	X-rays, bone survey, limited	0.45	0.14	0.16	0.14	0.16	0.02	XXX
77075		A	X-rays, bone survey complete	0.54	1.99	2.11	NA	NA	0.03	XXX
77075	TC	A	X-rays, bone survey complete	0.00	1.82	1.92	NA	NA	0.01	XXX

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77075	26	A	X-rays, bone survey complete	0.54	0.17	0.19	0.17	0.19	0.02	XXX
77076		A	X-rays, bone survey, infant	0.70	1.86	1.83	NA	NA	0.04	XXX
77076	TC	A	X-rays, bone survey, infant	0.00	1.65	1.61	NA	NA	0.01	XXX
77076	26	A	X-rays, bone survey, infant	0.70	0.21	0.22	0.21	0.22	0.03	XXX
77077		A	Joint survey, single view	0.31	0.69	0.78	NA	NA	0.04	XXX
77077	TC	A	Joint survey, single view	0.00	0.57	0.66	NA	NA	0.01	XXX
77077	26	A	Joint survey, single view	0.31	0.12	0.12	0.12	0.12	0.03	XXX
77078		A	Ct bone density, axial	0.25	4.22	4.35	NA	NA	0.02	XXX
77078	TC	A	Ct bone density, axial	0.00	4.14	4.26	NA	NA	0.01	XXX
77078	26	A	Ct bone density, axial	0.25	0.08	0.09	0.08	0.09	0.01	XXX
77079		A	Ct bone density, peripheral	0.22	0.78	1.20	NA	NA	0.02	XXX
77079	TC	A	Ct bone density, peripheral	0.00	0.70	1.13	NA	NA	0.01	XXX
77079	26	A	Ct bone density, peripheral	0.22	0.08	0.07	0.08	0.07	0.01	XXX
77080		A	Dxa bone density, axial	0.20	1.02	1.49	NA	NA	0.02	XXX
77080	TC	A	Dxa bone density, axial	0.00	0.95	1.42	NA	NA	0.01	XXX
77080	26	A	Dxa bone density, axial	0.20	0.07	0.07	0.07	0.07	0.01	XXX
77081		A	Dxa bone density/peripheral	0.22	0.47	0.54	NA	NA	0.02	XXX
77081	TC	A	Dxa bone density/peripheral	0.00	0.39	0.47	NA	NA	0.01	XXX
77081	26	A	Dxa bone density/peripheral	0.22	0.08	0.07	0.08	0.07	0.01	XXX
77082		A	Dxa bone density, vert fx	0.17	0.51	0.57	NA	NA	0.02	XXX
77082	TC	A	Dxa bone density, vert fx	0.00	0.45	0.52	NA	NA	0.01	XXX
77082	26	A	Dxa bone density, vert fx	0.17	0.06	0.05	0.06	0.05	0.01	XXX
77083		A	Radiographic absorptiometry	0.20	0.40	0.46	NA	NA	0.02	XXX
77083	TC	A	Radiographic absorptiometry	0.00	0.33	0.40	NA	NA	0.01	XXX
77083	26	A	Radiographic absorptiometry	0.20	0.07	0.06	0.07	0.06	0.01	XXX
77084		A	Magnetic image, bone marrow	1.60	13.02	13.82	NA	NA	0.08	XXX
77084	TC	A	Magnetic image, bone marrow	0.00	12.52	13.24	NA	NA	0.01	XXX
77084	26	A	Magnetic image, bone marrow	1.60	0.50	0.58	0.50	0.58	0.07	XXX
77261		A	Radiation therapy planning	1.39	0.61	0.54	0.61	0.54	0.08	XXX
77262		A	Radiation therapy planning	2.11	0.89	0.79	0.89	0.79	0.13	XXX
77263		A	Radiation therapy planning	3.14	1.33	1.17	1.33	1.17	0.19	XXX
77280		A	Set radiation therapy field	0.70	4.12	4.24	NA	NA	0.03	XXX
77280	TC	A	Set radiation therapy field	0.00	3.82	3.98	NA	NA	0.01	XXX
77280	26	A	Set radiation therapy field	0.70	0.30	0.26	0.30	0.26	0.02	XXX
77285		A	Set radiation therapy field	1.05	7.44	7.54	NA	NA	0.04	XXX
77285	TC	A	Set radiation therapy field	0.00	7.00	7.15	NA	NA	0.01	XXX
77285	26	A	Set radiation therapy field	1.05	0.44	0.39	0.44	0.39	0.03	XXX
77290		A	Set radiation therapy field	1.56	12.41	12.03	NA	NA	0.06	XXX
77290	TC	A	Set radiation therapy field	0.00	11.75	11.46	NA	NA	0.01	XXX

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77290	26	A	Set radiation therapy field	1.56	0.66	0.57	0.66	0.57	0.05	XXX
77295		A	Set radiation therapy field	4.56	7.34	11.70	NA	NA	0.19	XXX
77295	TC	A	Set radiation therapy field	0.00	5.41	10.03	NA	NA	0.04	XXX
77295	26	A	Set radiation therapy field	4.56	1.93	1.67	1.93	1.67	0.15	XXX
77299		C	Radiation therapy planning	0.00	0.00	0.00	NA	NA	0.00	XXX
77299	TC	C	Radiation therapy planning	0.00	0.00	0.00	NA	NA	0.00	XXX
77299	26	C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77300		A	Radiation therapy dose plan	0.62	1.15	1.26	NA	NA	0.03	XXX
77300	TC	A	Radiation therapy dose plan	0.00	0.89	1.03	NA	NA	0.01	XXX
77300	26	A	Radiation therapy dose plan	0.62	0.26	0.23	0.26	0.23	0.02	XXX
77301		A	Radiotherapy dose plan, imrt	7.99	53.19	51.60	NA	NA	0.45	XXX
77301	TC	A	Radiotherapy dose plan, imrt	0.00	49.83	48.67	NA	NA	0.18	XXX
77301	26	A	Radiotherapy dose plan, imrt	7.99	3.36	2.93	3.36	2.93	0.27	XXX
77305		A	Teletx isodose plan simple	0.70	0.90	1.15	NA	NA	0.03	XXX
77305	TC	A	Teletx isodose plan simple	0.00	0.61	0.89	NA	NA	0.01	XXX
77305	26	A	Teletx isodose plan simple	0.70	0.29	0.26	0.29	0.26	0.02	XXX
77310		A	Teletx isodose plan intermed	1.05	1.26	1.55	NA	NA	0.05	XXX
77310	TC	A	Teletx isodose plan intermed	0.00	0.82	1.16	NA	NA	0.01	XXX
77310	26	A	Teletx isodose plan intermed	1.05	0.44	0.39	0.44	0.39	0.04	XXX
77315		A	Teletx isodose plan complex	1.56	2.09	2.32	NA	NA	0.06	XXX
77315	TC	A	Teletx isodose plan complex	0.00	1.43	1.75	NA	NA	0.01	XXX
77315	26	A	Teletx isodose plan complex	1.56	0.66	0.57	0.66	0.57	0.05	XXX
77321		A	Special teletx port plan	0.95	1.49	2.07	NA	NA	0.04	XXX
77321	TC	A	Special teletx port plan	0.00	1.09	1.72	NA	NA	0.01	XXX
77321	26	A	Special teletx port plan	0.95	0.40	0.35	0.40	0.35	0.03	XXX
77326		A	Brachytx isodose calc simp	0.93	2.83	2.90	NA	NA	0.05	XXX
77326	TC	A	Brachytx isodose calc simp	0.00	2.44	2.56	NA	NA	0.02	XXX
77326	26	A	Brachytx isodose calc simp	0.93	0.39	0.34	0.39	0.34	0.03	XXX
77327		A	Brachytx isodose calc interm	1.39	3.90	4.04	NA	NA	0.08	XXX
77327	TC	A	Brachytx isodose calc interm	0.00	3.31	3.53	NA	NA	0.03	XXX
77327	26	A	Brachytx isodose calc interm	1.39	0.59	0.51	0.59	0.51	0.05	XXX
77328		A	Brachytx isodose plan compl	2.09	5.01	5.31	NA	NA	0.10	XXX
77328	TC	A	Brachytx isodose plan compl	0.00	4.13	4.54	NA	NA	0.03	XXX
77328	26	A	Brachytx isodose plan compl	2.09	0.88	0.77	0.88	0.77	0.07	XXX
77331		A	Special radiation dosimetry	0.87	0.84	0.82	NA	NA	0.04	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.47	0.50	NA	NA	0.01	XXX
77331	26	A	Special radiation dosimetry	0.87	0.37	0.32	0.37	0.32	0.03	XXX
77332		A	Radiation treatment aid(s)	0.54	1.48	1.54	NA	NA	0.03	XXX
77332	TC	A	Radiation treatment aid(s)	0.00	1.25	1.34	NA	NA	0.01	XXX

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77332	26	A	Radiation treatment aid(s)	0.54	0.23	0.20	0.23	0.20	0.02	XXX
77333		A	Radiation treatment aid(s)	0.84	0.58	0.86	NA	NA	0.04	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	0.22	0.55	NA	NA	0.01	XXX
77333	26	A	Radiation treatment aid(s)	0.84	0.36	0.31	0.36	0.31	0.03	XXX
77334		A	Radiation treatment aid(s)	1.24	2.62	2.90	NA	NA	0.05	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	2.10	2.45	NA	NA	0.01	XXX
77334	26	A	Radiation treatment aid(s)	1.24	0.52	0.45	0.52	0.45	0.04	XXX
77336		A	Radiation physics consult	0.00	1.04	1.47	NA	NA	0.01	XXX
77338		A	Design mlc device for imrt	4.29	8.79	8.79	NA	NA	0.15	XXX
77338	TC	A	Design mlc device for imrt	0.00	6.98	6.98	NA	NA	0.01	XXX
77338	26	A	Design mlc device for imrt	4.29	1.81	1.81	1.81	1.81	0.14	XXX
77370		A	Radiation physics consult	0.00	2.77	3.06	NA	NA	0.04	XXX
77371		C	Srs, multisource	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77372		A	Srs, linear based	0.00	20.84	22.30	NA	NA	0.05	XXX
77373		A	Sbrt delivery	0.00	38.80	41.42	NA	NA	0.06	XXX
77399		C	External radiation dosimetry	0.00	0.00	0.00	NA	NA	0.00	XXX
77399	TC	C	External radiation dosimetry	0.00	0.00	0.00	NA	NA	0.00	XXX
77399	26	C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77401		A	Radiation treatment delivery	0.00	0.42	0.71	NA	NA	0.01	XXX
77402		A	Radiation treatment delivery	0.00	3.83	3.76	NA	NA	0.01	XXX
77403		A	Radiation treatment delivery	0.00	3.41	3.31	NA	NA	0.01	XXX
77404		A	Radiation treatment delivery	0.00	3.83	3.67	NA	NA	0.01	XXX
77406		A	Radiation treatment delivery	0.00	3.89	3.70	NA	NA	0.01	XXX
77407		A	Radiation treatment delivery	0.00	6.79	6.12	NA	NA	0.01	XXX
77408		A	Radiation treatment delivery	0.00	4.70	4.48	NA	NA	0.01	XXX
77409		A	Radiation treatment delivery	0.00	5.25	4.96	NA	NA	0.01	XXX
77411		A	Radiation treatment delivery	0.00	5.25	4.94	NA	NA	0.01	XXX
77412		A	Radiation treatment delivery	0.00	6.20	5.82	NA	NA	0.01	XXX
77413		A	Radiation treatment delivery	0.00	6.24	5.86	NA	NA	0.01	XXX
77414		A	Radiation treatment delivery	0.00	7.02	6.54	NA	NA	0.01	XXX
77416		A	Radiation treatment delivery	0.00	7.05	6.57	NA	NA	0.01	XXX
77417		A	Radiology port film(s)	0.00	0.33	0.40	NA	NA	0.01	XXX
77418		A	Radiation tx delivery, imrt	0.00	12.00	13.88	NA	NA	0.01	XXX
77421		A	Stereoscopic x-ray guidance	0.39	2.22	2.57	NA	NA	0.02	XXX
77421	TC	A	Stereoscopic x-ray guidance	0.00	2.06	2.43	NA	NA	0.01	XXX
77421	26	A	Stereoscopic x-ray guidance	0.39	0.16	0.14	0.16	0.14	0.01	XXX
77422		A	Neutron beam tx, simple	0.00	6.17	5.57	NA	NA	0.01	XXX
77423		A	Neutron beam tx, complex	0.00	6.81	6.33	NA	NA	0.02	XXX
77427		A	Radiation tx management, x5	3.70	1.72	1.47	1.72	1.47	0.22	XXX

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77431		A	Radiation therapy management	1.81	0.93	0.82	0.93	0.82	0.11	XXX
77432		A	Stereotactic radiation trmt	7.92	3.37	2.98	3.37	2.98	0.47	XXX
77435		A	Sbrt management	13.00	5.80	5.10	NA	NA	0.77	XXX
77470		A	Special radiation treatment	2.09	2.01	3.88	NA	NA	0.08	XXX
77470	TC	A	Special radiation treatment	0.00	1.13	3.11	NA	NA	0.01	XXX
77470	26	A	Special radiation treatment	2.09	0.88	0.77	0.88	0.77	0.07	XXX
77499		C	Radiation therapy management	0.00	0.00	0.00	NA	NA	0.00	XXX
77499	TC	C	Radiation therapy management	0.00	0.00	0.00	NA	NA	0.00	XXX
77499	26	C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77520		C	Proton trmt, simple w/o comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77522		C	Proton trmt, simple w/comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77523		C	Proton trmt, intermediate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77525		C	Proton treatment, complex	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77600		R	Hyperthermia treatment	1.56	9.50	8.83	NA	NA	0.08	XXX
77600	TC	R	Hyperthermia treatment	0.00	8.83	8.26	NA	NA	0.03	XXX
77600	26	R	Hyperthermia treatment	1.56	0.67	0.57	0.67	0.57	0.05	XXX
77605		R	Hyperthermia treatment	2.09	25.93	18.63	NA	NA	0.28	XXX
77605	TC	R	Hyperthermia treatment	0.00	25.16	17.98	NA	NA	0.01	XXX
77605	26	R	Hyperthermia treatment	2.09	0.77	0.65	0.77	0.65	0.27	XXX
77610		R	Hyperthermia treatment	1.56	15.49	15.56	NA	NA	0.08	XXX
77610	TC	R	Hyperthermia treatment	0.00	14.83	15.03	NA	NA	0.03	XXX
77610	26	R	Hyperthermia treatment	1.56	0.66	0.53	0.66	0.53	0.05	XXX
77615		R	Hyperthermia treatment	2.09	23.94	22.62	NA	NA	0.14	XXX
77615	TC	R	Hyperthermia treatment	0.00	23.05	21.86	NA	NA	0.07	XXX
77615	26	R	Hyperthermia treatment	2.09	0.89	0.76	0.89	0.76	0.07	XXX
77620		R	Hyperthermia treatment	1.56	12.28	9.85	NA	NA	0.06	XXX
77620	TC	R	Hyperthermia treatment	0.00	11.71	9.35	NA	NA	0.03	XXX
77620	26	R	Hyperthermia treatment	1.56	0.57	0.50	0.57	0.50	0.03	XXX
77750		A	Infuse radioactive materials	5.00	4.78	4.37	NA	NA	0.20	090
77750	TC	A	Infuse radioactive materials	0.00	2.66	2.55	NA	NA	0.03	090
77750	26	A	Infuse radioactive materials	5.00	2.12	1.82	2.12	1.82	0.17	090
77761		A	Apply intrcav radiat simple	3.85	6.15	5.83	NA	NA	0.17	090
77761	TC	A	Apply intrcav radiat simple	0.00	4.60	4.47	NA	NA	0.04	090
77761	26	A	Apply intrcav radiat simple	3.85	1.55	1.36	1.55	1.36	0.13	090
77762		A	Apply intrcav radiat interm	5.76	7.68	7.35	NA	NA	0.24	090
77762	TC	A	Apply intrcav radiat interm	0.00	5.27	5.25	NA	NA	0.05	090
77762	26	A	Apply intrcav radiat interm	5.76	2.41	2.10	2.41	2.10	0.19	090
77763		A	Apply intrcav radiat compl	8.66	10.40	9.92	NA	NA	0.35	090
77763	TC	A	Apply intrcav radiat compl	0.00	6.83	6.78	NA	NA	0.06	090

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77763	26	A	Apply intrcav radiat compl	8.66	3.57	3.14	3.57	3.14	0.29	090
77776		A	Apply interstit radiat simpl	4.70	6.61	6.45	NA	NA	0.26	090
77776	TC	A	Apply interstit radiat simpl	0.00	4.84	4.81	NA	NA	0.05	090
77776	26	A	Apply interstit radiat simpl	4.70	1.77	1.64	1.77	1.64	0.21	090
77777		A	Apply interstit radiat inter	7.52	7.91	7.97	NA	NA	0.38	090
77777	TC	A	Apply interstit radiat inter	0.00	4.99	5.19	NA	NA	0.05	090
77777	26	A	Apply interstit radiat inter	7.52	2.92	2.78	2.92	2.78	0.33	090
77778		A	Apply interstit radiat compl	11.32	11.62	11.12	NA	NA	0.46	090
77778	TC	A	Apply interstit radiat compl	0.00	6.91	6.99	NA	NA	0.07	090
77778	26	A	Apply interstit radiat compl	11.32	4.71	4.13	4.71	4.13	0.39	090
77785		A	Hdr brachytx, 1 channel	1.42	3.43	3.58	NA	NA	0.04	XXX
77785	TC	A	Hdr brachytx, 1 channel	0.00	2.83	3.05	NA	NA	0.01	XXX
77785	26	A	Hdr brachytx, 1 channel	1.42	0.60	0.53	0.60	0.53	0.03	XXX
77786		A	Hdr brachytx, 2-12 channel	3.25	7.99	10.99	NA	NA	0.11	XXX
77786	TC	A	Hdr brachytx, 2-12 channel	0.00	6.61	9.85	NA	NA	0.03	XXX
77786	26	A	Hdr brachytx, 2-12 channel	3.25	1.38	1.14	1.38	1.14	0.08	XXX
77787		A	Hdr brachytx over 12 chan	4.89	13.99	16.83	NA	NA	0.19	XXX
77787	TC	A	Hdr brachytx over 12 chan	0.00	11.91	15.00	NA	NA	0.07	XXX
77787	26	A	Hdr brachytx over 12 chan	4.89	2.08	1.83	2.08	1.83	0.12	XXX
77789		A	Apply surface radiation	1.14	1.97	1.78	NA	NA	0.05	000
77789	TC	A	Apply surface radiation	0.00	1.46	1.35	NA	NA	0.01	000
77789	26	A	Apply surface radiation	1.14	0.51	0.43	0.51	0.43	0.04	000
77790		A	Radiation handling	1.05	1.46	1.37	NA	NA	0.04	XXX
77790	TC	A	Radiation handling	0.00	1.02	0.98	NA	NA	0.01	XXX
77790	26	A	Radiation handling	1.05	0.44	0.39	0.44	0.39	0.03	XXX
77799		C	Radium/radioisotope therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
77799	TC	C	Radium/radioisotope therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
77799	26	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78000		A	Thyroid, single uptake	0.19	1.50	1.63	NA	NA	0.03	XXX
78000	TC	A	Thyroid, single uptake	0.00	1.45	1.56	NA	NA	0.02	XXX
78000	26	A	Thyroid, single uptake	0.19	0.05	0.07	0.05	0.07	0.01	XXX
78001		A	Thyroid, multiple uptakes	0.26	1.92	2.07	NA	NA	0.03	XXX
78001	TC	A	Thyroid, multiple uptakes	0.00	1.85	1.97	NA	NA	0.02	XXX
78001	26	A	Thyroid, multiple uptakes	0.26	0.07	0.10	0.07	0.10	0.01	XXX
78003		A	Thyroid suppress/stimul	0.33	1.62	1.71	NA	NA	0.03	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	1.52	1.59	NA	NA	0.02	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.10	0.12	0.10	0.12	0.01	XXX
78006		A	Thyroid imaging with uptake	0.49	5.32	5.38	NA	NA	0.05	XXX
78006	TC	A	Thyroid imaging with uptake	0.00	5.18	5.21	NA	NA	0.03	XXX

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78006	26	A	Thyroid imaging with uptake	0.49	0.14	0.17	0.14	0.17	0.02	XXX
78007		A	Thyroid image, mult uptakes	0.50	2.53	2.91	NA	NA	0.05	XXX
78007	TC	A	Thyroid image, mult uptakes	0.00	2.39	2.73	NA	NA	0.03	XXX
78007	26	A	Thyroid image, mult uptakes	0.50	0.14	0.18	0.14	0.18	0.02	XXX
78010		A	Thyroid imaging	0.39	3.59	3.66	NA	NA	0.03	XXX
78010	TC	A	Thyroid imaging	0.00	3.48	3.53	NA	NA	0.02	XXX
78010	26	A	Thyroid imaging	0.39	0.11	0.13	0.11	0.13	0.01	XXX
78011		A	Thyroid imaging with flow	0.45	3.82	4.10	NA	NA	0.03	XXX
78011	TC	A	Thyroid imaging with flow	0.00	3.69	3.94	NA	NA	0.02	XXX
78011	26	A	Thyroid imaging with flow	0.45	0.13	0.16	0.13	0.16	0.01	XXX
78015		A	Thyroid met imaging	0.67	4.49	4.75	NA	NA	0.05	XXX
78015	TC	A	Thyroid met imaging	0.00	4.32	4.52	NA	NA	0.02	XXX
78015	26	A	Thyroid met imaging	0.67	0.17	0.23	0.17	0.23	0.03	XXX
78016		A	Thyroid met imaging/studies	0.82	6.04	7.21	NA	NA	0.04	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	5.93	6.94	NA	NA	0.03	XXX
78016	26	A	Thyroid met imaging/studies	0.82	0.11	0.27	0.11	0.27	0.01	XXX
78018		A	Thyroid met imaging, body	0.86	6.65	7.32	NA	NA	0.06	XXX
78018	TC	A	Thyroid met imaging, body	0.00	6.43	7.02	NA	NA	0.03	XXX
78018	26	A	Thyroid met imaging, body	0.86	0.22	0.30	0.22	0.30	0.03	XXX
78020		A	Thyroid met uptake	0.60	1.40	1.70	NA	NA	0.03	ZZZ
78020	TC	A	Thyroid met uptake	0.00	1.26	1.49	NA	NA	0.01	ZZZ
78020	26	A	Thyroid met uptake	0.60	0.14	0.21	0.14	0.21	0.02	ZZZ
78070		A	Parathyroid nuclear imaging	0.82	2.86	3.59	NA	NA	0.06	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	2.63	3.30	NA	NA	0.03	XXX
78070	26	A	Parathyroid nuclear imaging	0.82	0.23	0.29	0.23	0.29	0.03	XXX
78075		A	Adrenal nuclear imaging	0.74	9.46	10.07	NA	NA	0.07	XXX
78075	TC	A	Adrenal nuclear imaging	0.00	9.28	9.81	NA	NA	0.04	XXX
78075	26	A	Adrenal nuclear imaging	0.74	0.18	0.26	0.18	0.26	0.03	XXX
78099		C	Endocrine nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78099	TC	C	Endocrine nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78099	26	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78102		A	Bone marrow imaging, ltd	0.55	3.44	3.70	NA	NA	0.04	XXX
78102	TC	A	Bone marrow imaging, ltd	0.00	3.30	3.50	NA	NA	0.02	XXX
78102	26	A	Bone marrow imaging, ltd	0.55	0.14	0.20	0.14	0.20	0.02	XXX
78103		A	Bone marrow imaging, mult	0.75	4.50	4.92	NA	NA	0.05	XXX
78103	TC	A	Bone marrow imaging, mult	0.00	4.31	4.66	NA	NA	0.02	XXX
78103	26	A	Bone marrow imaging, mult	0.75	0.19	0.26	0.19	0.26	0.03	XXX
78104		A	Bone marrow imaging, body	0.80	5.11	5.66	NA	NA	0.05	XXX
78104	TC	A	Bone marrow imaging, body	0.00	4.90	5.37	NA	NA	0.02	XXX

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78104	26	A	Bone marrow imaging, body	0.80	0.21	0.29	0.21	0.29	0.03	XXX
78110		A	Plasma volume, single	0.19	1.84	1.87	NA	NA	0.03	XXX
78110	TC	A	Plasma volume, single	0.00	1.78	1.80	NA	NA	0.02	XXX
78110	26	A	Plasma volume, single	0.19	0.06	0.07	0.06	0.07	0.01	XXX
78111		A	Plasma volume, multiple	0.22	1.52	2.17	NA	NA	0.03	XXX
78111	TC	A	Plasma volume, multiple	0.00	1.48	2.09	NA	NA	0.02	XXX
78111	26	A	Plasma volume, multiple	0.22	0.04	0.08	0.04	0.08	0.01	XXX
78120		A	Red cell mass, single	0.23	1.67	1.98	NA	NA	0.03	XXX
78120	TC	A	Red cell mass, single	0.00	1.61	1.90	NA	NA	0.02	XXX
78120	26	A	Red cell mass, single	0.23	0.06	0.08	0.06	0.08	0.01	XXX
78121		A	Red cell mass, multiple	0.32	1.42	2.22	NA	NA	0.03	XXX
78121	TC	A	Red cell mass, multiple	0.00	1.38	2.12	NA	NA	0.02	XXX
78121	26	A	Red cell mass, multiple	0.32	0.04	0.10	0.04	0.10	0.01	XXX
78122		A	Blood volume	0.45	1.72	2.67	NA	NA	0.03	XXX
78122	TC	A	Blood volume	0.00	1.62	2.51	NA	NA	0.02	XXX
78122	26	A	Blood volume	0.45	0.10	0.16	0.10	0.16	0.01	XXX
78130		A	Red cell survival study	0.61	3.00	3.37	NA	NA	0.06	XXX
78130	TC	A	Red cell survival study	0.00	2.81	3.15	NA	NA	0.03	XXX
78130	26	A	Red cell survival study	0.61	0.19	0.22	0.19	0.22	0.03	XXX
78135		A	Red cell survival kinetics	0.64	7.72	7.92	NA	NA	0.06	XXX
78135	TC	A	Red cell survival kinetics	0.00	7.52	7.69	NA	NA	0.03	XXX
78135	26	A	Red cell survival kinetics	0.64	0.20	0.23	0.20	0.23	0.03	XXX
78140		A	Red cell sequestration	0.61	2.42	3.08	NA	NA	0.05	XXX
78140	TC	A	Red cell sequestration	0.00	2.24	2.86	NA	NA	0.02	XXX
78140	26	A	Red cell sequestration	0.61	0.18	0.22	0.18	0.22	0.03	XXX
78185		A	Spleen imaging	0.40	4.48	4.60	NA	NA	0.03	XXX
78185	TC	A	Spleen imaging	0.00	4.37	4.46	NA	NA	0.02	XXX
78185	26	A	Spleen imaging	0.40	0.11	0.14	0.11	0.14	0.01	XXX
78190		A	Platelet survival, kinetics	1.09	9.03	8.81	NA	NA	0.06	XXX
78190	TC	A	Platelet survival, kinetics	0.00	8.63	8.43	NA	NA	0.03	XXX
78190	26	A	Platelet survival, kinetics	1.09	0.40	0.38	0.40	0.38	0.03	XXX
78191		A	Platelet survival	0.61	2.98	4.18	NA	NA	0.06	XXX
78191	TC	A	Platelet survival	0.00	2.79	3.97	NA	NA	0.03	XXX
78191	26	A	Platelet survival	0.61	0.19	0.21	0.19	0.21	0.03	XXX
78195		A	Lymph system imaging	1.20	7.45	7.71	NA	NA	0.08	XXX
78195	TC	A	Lymph system imaging	0.00	7.12	7.28	NA	NA	0.03	XXX
78195	26	A	Lymph system imaging	1.20	0.33	0.43	0.33	0.43	0.05	XXX
78199		C	Blood/lymph nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78199	TC	C	Blood/lymph nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX

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78199	26	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78201		A	Liver imaging	0.44	4.21	4.21	NA	NA	0.05	XXX
78201	TC	A	Liver imaging	0.00	4.09	4.06	NA	NA	0.02	XXX
78201	26	A	Liver imaging	0.44	0.12	0.15	0.12	0.15	0.03	XXX
78202		A	Liver imaging with flow	0.51	4.29	4.72	NA	NA	0.03	XXX
78202	TC	A	Liver imaging with flow	0.00	4.17	4.55	NA	NA	0.02	XXX
78202	26	A	Liver imaging with flow	0.51	0.12	0.17	0.12	0.17	0.01	XXX
78205		A	Liver imaging (3D)	0.71	4.42	5.30	NA	NA	0.05	XXX
78205	TC	A	Liver imaging (3D)	0.00	4.23	5.05	NA	NA	0.02	XXX
78205	26	A	Liver imaging (3D)	0.71	0.19	0.25	0.19	0.25	0.03	XXX
78206		A	Liver image (3d) with flow	0.96	7.47	7.97	NA	NA	0.06	XXX
78206	TC	A	Liver image (3d) with flow	0.00	7.20	7.63	NA	NA	0.03	XXX
78206	26	A	Liver image (3d) with flow	0.96	0.27	0.34	0.27	0.34	0.03	XXX
78215		A	Liver and spleen imaging	0.49	4.10	4.37	NA	NA	0.04	XXX
78215	TC	A	Liver and spleen imaging	0.00	3.96	4.20	NA	NA	0.02	XXX
78215	26	A	Liver and spleen imaging	0.49	0.14	0.17	0.14	0.17	0.02	XXX
78216		A	Liver & spleen image/flow	0.57	2.34	2.92	NA	NA	0.04	XXX
78216	TC	A	Liver & spleen image/flow	0.00	2.18	2.72	NA	NA	0.02	XXX
78216	26	A	Liver & spleen image/flow	0.57	0.16	0.20	0.16	0.20	0.02	XXX
78220		A	Liver function study	0.49	2.54	3.14	NA	NA	0.04	XXX
78220	TC	A	Liver function study	0.00	2.40	2.97	NA	NA	0.03	XXX
78220	26	A	Liver function study	0.49	0.14	0.17	0.14	0.17	0.01	XXX
78223		A	Hepatobiliary imaging	0.84	7.33	7.45	NA	NA	0.06	XXX
78223	TC	A	Hepatobiliary imaging	0.00	7.09	7.15	NA	NA	0.03	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.24	0.30	0.24	0.30	0.03	XXX
78230		A	Salivary gland imaging	0.45	3.60	3.72	NA	NA	0.04	XXX
78230	TC	A	Salivary gland imaging	0.00	3.46	3.56	NA	NA	0.02	XXX
78230	26	A	Salivary gland imaging	0.45	0.14	0.16	0.14	0.16	0.02	XXX
78231		A	Serial salivary imaging	0.52	2.39	2.86	NA	NA	0.03	XXX
78231	TC	A	Serial salivary imaging	0.00	2.23	2.68	NA	NA	0.02	XXX
78231	26	A	Serial salivary imaging	0.52	0.16	0.18	0.16	0.18	0.01	XXX
78232		A	Salivary gland function exam	0.47	1.83	2.80	NA	NA	0.04	XXX
78232	TC	A	Salivary gland function exam	0.00	1.76	2.65	NA	NA	0.02	XXX
78232	26	A	Salivary gland function exam	0.47	0.07	0.15	0.07	0.15	0.02	XXX
78258		A	Esophageal motility study	0.74	5.12	5.14	NA	NA	0.04	XXX
78258	TC	A	Esophageal motility study	0.00	4.88	4.86	NA	NA	0.02	XXX
78258	26	A	Esophageal motility study	0.74	0.24	0.28	0.24	0.28	0.02	XXX
78261		A	Gastric mucosa imaging	0.69	5.29	5.65	NA	NA	0.05	XXX
78261	TC	A	Gastric mucosa imaging	0.00	5.08	5.40	NA	NA	0.02	XXX

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78261	26	A	Gastric mucosa imaging	0.69	0.21	0.25	0.21	0.25	0.03	XXX
78262		A	Gastroesophageal reflux exam	0.68	5.23	5.58	NA	NA	0.03	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	5.04	5.35	NA	NA	0.02	XXX
78262	26	A	Gastroesophageal reflux exam	0.68	0.19	0.23	0.19	0.23	0.01	XXX
78264		A	Gastric emptying study	0.78	6.11	6.47	NA	NA	0.06	XXX
78264	TC	A	Gastric emptying study	0.00	5.89	6.19	NA	NA	0.03	XXX
78264	26	A	Gastric emptying study	0.78	0.22	0.28	0.22	0.28	0.03	XXX
78267		X	Breath tst attain/anal c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78268		X	Breath test analysis, c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78270		A	Vit B-12 absorption exam	0.20	1.70	1.86	NA	NA	0.03	XXX
78270	TC	A	Vit B-12 absorption exam	0.00	1.64	1.79	NA	NA	0.02	XXX
78270	26	A	Vit B-12 absorption exam	0.20	0.06	0.07	0.06	0.07	0.01	XXX
78271		A	Vit b-12 absrp exam, int fac	0.20	2.00	1.94	NA	NA	0.03	XXX
78271	TC	A	Vit b-12 absrp exam, int fac	0.00	1.93	1.88	NA	NA	0.02	XXX
78271	26	A	Vit b-12 absrp exam, int fac	0.20	0.07	0.06	0.07	0.06	0.01	XXX
78272		A	Vit B-12 absorp, combined	0.27	1.83	2.06	NA	NA	0.03	XXX
78272	TC	A	Vit B-12 absorp, combined	0.00	1.75	1.98	NA	NA	0.02	XXX
78272	26	A	Vit B-12 absorp, combined	0.27	0.08	0.08	0.08	0.08	0.01	XXX
78278		A	Acute GI blood loss imaging	0.99	7.37	7.76	NA	NA	0.07	XXX
78278	TC	A	Acute GI blood loss imaging	0.00	7.09	7.41	NA	NA	0.03	XXX
78278	26	A	Acute GI blood loss imaging	0.99	0.28	0.35	0.28	0.35	0.04	XXX
78282		C	GI protein loss exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78282	TC	C	GI protein loss exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78282	26	A	GI protein loss exam	0.38	0.11	0.14	0.11	0.14	0.03	XXX
78290		A	Meckels divert exam	0.68	7.29	7.32	NA	NA	0.06	XXX
78290	TC	A	Meckels divert exam	0.00	7.10	7.07	NA	NA	0.03	XXX
78290	26	A	Meckels divert exam	0.68	0.19	0.25	0.19	0.25	0.03	XXX
78291		A	Leveen/shunt patency exam	0.88	5.28	5.51	NA	NA	0.06	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	5.04	5.20	NA	NA	0.02	XXX
78291	26	A	Leveen/shunt patency exam	0.88	0.24	0.31	0.24	0.31	0.04	XXX
78299		C	GI nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78299	TC	C	GI nuclear procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
78299	26	C	GI nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78300		A	Bone imaging, limited area	0.62	3.66	3.84	NA	NA	0.04	XXX
78300	TC	A	Bone imaging, limited area	0.00	3.47	3.62	NA	NA	0.02	XXX
78300	26	A	Bone imaging, limited area	0.62	0.19	0.22	0.19	0.22	0.02	XXX
78305		A	Bone imaging, multiple areas	0.83	4.77	5.08	NA	NA	0.05	XXX
78305	TC	A	Bone imaging, multiple areas	0.00	4.53	4.79	NA	NA	0.02	XXX
78305	26	A	Bone imaging, multiple areas	0.83	0.24	0.29	0.24	0.29	0.03	XXX

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78306		A	Bone imaging, whole body	0.86	5.16	5.64	NA	NA	0.05	XXX
78306	TC	A	Bone imaging, whole body	0.00	4.92	5.33	NA	NA	0.02	XXX
78306	26	A	Bone imaging, whole body	0.86	0.24	0.31	0.24	0.31	0.03	XXX
78315		A	Bone imaging, 3 phase	1.02	7.34	7.73	NA	NA	0.07	XXX
78315	TC	A	Bone imaging, 3 phase	0.00	7.05	7.37	NA	NA	0.03	XXX
78315	26	A	Bone imaging, 3 phase	1.02	0.29	0.36	0.29	0.36	0.04	XXX
78320		A	Bone imaging (3D)	1.04	4.48	5.41	NA	NA	0.06	XXX
78320	TC	A	Bone imaging (3D)	0.00	4.20	5.04	NA	NA	0.02	XXX
78320	26	A	Bone imaging (3D)	1.04	0.28	0.37	0.28	0.37	0.04	XXX
78350		N	Bone mineral, single photon	0.22	0.58	0.64	NA	NA	0.02	XXX
78350	TC	N	Bone mineral, single photon	0.00	0.50	0.57	NA	NA	0.01	XXX
78350	26	N	Bone mineral, single photon	0.22	0.08	0.07	0.08	0.07	0.01	XXX
78351		N	Bone mineral, dual photon	0.30	0.11	0.11	0.11	0.11	0.02	XXX
78399		C	Musculoskeletal nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78399	TC	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78399	26	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78414		C	Non-imaging heart function	0.00	0.00	0.00	NA	NA	0.00	XXX
78414	TC	C	Non-imaging heart function	0.00	0.00	0.00	NA	NA	0.00	XXX
78414	26	A	Non-imaging heart function	0.45	0.17	0.14	0.17	0.14	0.02	XXX
78428		A	Cardiac shunt imaging	0.78	3.94	4.35	NA	NA	0.04	XXX
78428	TC	A	Cardiac shunt imaging	0.00	3.73	4.04	NA	NA	0.02	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.21	0.31	0.21	0.31	0.02	XXX
78445		A	Vascular flow imaging	0.49	3.64	3.87	NA	NA	0.03	XXX
78445	TC	A	Vascular flow imaging	0.00	3.52	3.70	NA	NA	0.02	XXX
78445	26	A	Vascular flow imaging	0.49	0.12	0.17	0.12	0.17	0.01	XXX
78451		A	Ht muscle image spect, sing	1.38	4.73	4.73	NA	NA	0.05	XXX
78451	TC	A	Ht muscle image spect, sing	0.00	4.30	4.30	NA	NA	0.01	XXX
78451	26	A	Ht muscle image spect, sing	1.38	0.43	0.43	0.43	0.43	0.04	XXX
78452		A	Ht muscle image spect, mult	1.62	8.84	8.84	NA	NA	0.06	XXX
78452	TC	A	Ht muscle image spect, mult	0.00	8.32	8.32	NA	NA	0.01	XXX
78452	26	A	Ht muscle image spect, mult	1.62	0.52	0.52	0.52	0.52	0.05	XXX
78453		A	Ht muscle image,planar,sing	1.00	4.32	4.32	NA	NA	0.04	XXX
78453	TC	A	Ht muscle image,planar,sing	0.00	4.01	4.01	NA	NA	0.01	XXX
78453	26	A	Ht muscle image,planar,sing	1.00	0.31	0.31	0.31	0.31	0.03	XXX
78454		A	Ht musc image, planar, mult	1.34	3.77	3.77	NA	NA	0.05	XXX
78454	TC	A	Ht musc image, planar, mult	0.00	3.37	3.37	NA	NA	0.01	XXX
78454	26	A	Ht musc image, planar, mult	1.34	0.40	0.40	0.40	0.40	0.04	XXX
78456		A	Acute venous thrombus image	1.00	7.12	8.04	NA	NA	0.05	XXX
78456	TC	A	Acute venous thrombus image	0.00	6.79	7.60	NA	NA	0.03	XXX

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78456	26	A	Acute venous thrombus image	1.00	0.33	0.44	0.33	0.44	0.02	XXX
78457		A	Venous thrombosis imaging	0.77	4.00	4.23	NA	NA	0.04	XXX
78457	TC	A	Venous thrombosis imaging	0.00	3.77	3.96	NA	NA	0.01	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.23	0.27	0.23	0.27	0.03	XXX
78458		A	Ven thrombosis images, bilat	0.90	3.58	4.38	NA	NA	0.06	XXX
78458	TC	A	Ven thrombosis images, bilat	0.00	3.38	4.07	NA	NA	0.02	XXX
78458	26	A	Ven thrombosis images, bilat	0.90	0.20	0.31	0.20	0.31	0.04	XXX
78459		C	Heart muscle imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78459	TC	C	Heart muscle imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78459	26	A	Heart muscle imaging (PET)	1.50	0.37	0.59	0.37	0.59	0.08	XXX
78466		A	Heart infarct image	0.69	3.54	4.00	NA	NA	0.04	XXX
78466	TC	A	Heart infarct image	0.00	3.33	3.72	NA	NA	0.02	XXX
78466	26	A	Heart infarct image	0.69	0.21	0.28	0.21	0.28	0.02	XXX
78468		A	Heart infarct image (ef)	0.80	4.20	5.03	NA	NA	0.04	XXX
78468	TC	A	Heart infarct image (ef)	0.00	3.94	4.68	NA	NA	0.02	XXX
78468	26	A	Heart infarct image (ef)	0.80	0.26	0.35	0.26	0.35	0.02	XXX
78469		A	Heart infarct image (3D)	0.92	4.98	5.72	NA	NA	0.04	XXX
78469	TC	A	Heart infarct image (3D)	0.00	4.67	5.34	NA	NA	0.02	XXX
78469	26	A	Heart infarct image (3D)	0.92	0.31	0.38	0.31	0.38	0.02	XXX
78472		A	Gated heart, planar, single	0.98	4.71	5.69	NA	NA	0.05	XXX
78472	TC	A	Gated heart, planar, single	0.00	4.42	5.30	NA	NA	0.02	XXX
78472	26	A	Gated heart, planar, single	0.98	0.29	0.39	0.29	0.39	0.03	XXX
78473		A	Gated heart, multiple	1.47	5.91	7.53	NA	NA	0.06	XXX
78473	TC	A	Gated heart, multiple	0.00	5.45	6.92	NA	NA	0.03	XXX
78473	26	A	Gated heart, multiple	1.47	0.46	0.61	0.46	0.61	0.03	XXX
78481		A	Heart first pass, single	0.98	3.61	4.76	NA	NA	0.04	XXX
78481	TC	A	Heart first pass, single	0.00	3.28	4.32	NA	NA	0.02	XXX
78481	26	A	Heart first pass, single	0.98	0.33	0.44	0.33	0.44	0.02	XXX
78483		A	Heart first pass, multiple	1.47	4.76	6.57	NA	NA	0.05	XXX
78483	TC	A	Heart first pass, multiple	0.00	4.28	5.89	NA	NA	0.02	XXX
78483	26	A	Heart first pass, multiple	1.47	0.48	0.68	0.48	0.68	0.03	XXX
78491		C	Heart image (pet), single	0.00	0.00	0.00	NA	NA	0.00	XXX
78491	TC	C	Heart image (pet), single	0.00	0.00	0.00	NA	NA	0.00	XXX
78491	26	A	Heart image (pet), single	1.50	0.42	0.62	0.42	0.62	0.08	XXX
78492		C	Heart image (pet), multiple	0.00	0.00	0.00	NA	NA	0.00	XXX
78492	TC	C	Heart image (pet), multiple	0.00	0.00	0.00	NA	NA	0.00	XXX
78492	26	A	Heart image (pet), multiple	1.87	0.54	0.80	0.54	0.80	0.09	XXX
78494		A	Heart image, spect	1.19	4.75	6.03	NA	NA	0.05	XXX
78494	TC	A	Heart image, spect	0.00	4.35	5.54	NA	NA	0.02	XXX

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78494	26	A	Heart image, spect	1.19	0.40	0.49	0.40	0.49	0.03	XXX
78496		A	Heart first pass add-on	0.50	0.63	2.05	NA	NA	0.02	ZZZ
78496	TC	A	Heart first pass add-on	0.00	0.47	1.83	NA	NA	0.01	ZZZ
78496	26	A	Heart first pass add-on	0.50	0.16	0.22	0.16	0.22	0.01	ZZZ
78499		C	Cardiovascular nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78499	TC	C	Cardiovascular nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78499	26	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78580		A	Lung perfusion imaging	0.74	4.29	4.71	NA	NA	0.04	XXX
78580	TC	A	Lung perfusion imaging	0.00	4.08	4.44	NA	NA	0.02	XXX
78580	26	A	Lung perfusion imaging	0.74	0.21	0.27	0.21	0.27	0.02	XXX
78584		A	Lung V/Q image single breath	0.99	2.52	3.04	NA	NA	0.06	XXX
78584	TC	A	Lung V/Q image single breath	0.00	2.23	2.68	NA	NA	0.02	XXX
78584	26	A	Lung V/Q image single breath	0.99	0.29	0.36	0.29	0.36	0.04	XXX
78585		A	Lung V/Q imaging	1.09	7.36	7.93	NA	NA	0.06	XXX
78585	TC	A	Lung V/Q imaging	0.00	7.06	7.54	NA	NA	0.03	XXX
78585	26	A	Lung V/Q imaging	1.09	0.30	0.39	0.30	0.39	0.03	XXX
78586		A	Aerosol lung image, single	0.40	3.60	3.79	NA	NA	0.03	XXX
78586	TC	A	Aerosol lung image, single	0.00	3.48	3.65	NA	NA	0.02	XXX
78586	26	A	Aerosol lung image, single	0.40	0.12	0.14	0.12	0.14	0.01	XXX
78587		A	Aerosol lung image, multiple	0.49	4.52	4.81	NA	NA	0.03	XXX
78587	TC	A	Aerosol lung image, multiple	0.00	4.39	4.63	NA	NA	0.02	XXX
78587	26	A	Aerosol lung image, multiple	0.49	0.13	0.18	0.13	0.18	0.01	XXX
78588		A	Perfusion lung image	1.09	7.43	7.50	NA	NA	0.07	XXX
78588	TC	A	Perfusion lung image	0.00	7.12	7.11	NA	NA	0.03	XXX
78588	26	A	Perfusion lung image	1.09	0.31	0.39	0.31	0.39	0.04	XXX
78591		A	Vent image, 1 breath, 1 proj	0.40	3.59	3.84	NA	NA	0.03	XXX
78591	TC	A	Vent image, 1 breath, 1 proj	0.00	3.47	3.70	NA	NA	0.02	XXX
78591	26	A	Vent image, 1 breath, 1 proj	0.40	0.12	0.14	0.12	0.14	0.01	XXX
78593		A	Vent image, 1 proj, gas	0.49	4.12	4.48	NA	NA	0.04	XXX
78593	TC	A	Vent image, 1 proj, gas	0.00	3.98	4.31	NA	NA	0.02	XXX
78593	26	A	Vent image, 1 proj, gas	0.49	0.14	0.17	0.14	0.17	0.02	XXX
78594		A	Vent image, mult proj, gas	0.53	4.37	5.14	NA	NA	0.04	XXX
78594	TC	A	Vent image, mult proj, gas	0.00	4.24	4.95	NA	NA	0.02	XXX
78594	26	A	Vent image, mult proj, gas	0.53	0.13	0.19	0.13	0.19	0.02	XXX
78596		A	Lung differential function	1.27	7.57	8.33	NA	NA	0.06	XXX
78596	TC	A	Lung differential function	0.00	7.22	7.91	NA	NA	0.03	XXX
78596	26	A	Lung differential function	1.27	0.35	0.42	0.35	0.42	0.03	XXX
78599		C	Respiratory nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78599	TC	C	Respiratory nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX

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78599	26	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78600		A	Brain image < 4 views	0.44	3.86	4.12	NA	NA	0.03	XXX
78600	TC	A	Brain image < 4 views	0.00	3.73	3.96	NA	NA	0.02	XXX
78600	26	A	Brain image < 4 views	0.44	0.13	0.16	0.13	0.16	0.01	XXX
78601		A	Brain image w/flow < 4 views	0.51	4.53	4.90	NA	NA	0.04	XXX
78601	TC	A	Brain image w/flow < 4 views	0.00	4.39	4.72	NA	NA	0.02	XXX
78601	26	A	Brain image w/flow < 4 views	0.51	0.14	0.18	0.14	0.18	0.02	XXX
78605		A	Brain image 4+ views	0.53	4.11	4.50	NA	NA	0.04	XXX
78605	TC	A	Brain image 4+ views	0.00	3.96	4.30	NA	NA	0.02	XXX
78605	26	A	Brain image 4+ views	0.53	0.15	0.20	0.15	0.20	0.02	XXX
78606		A	Brain image w/flow 4 + views	0.64	7.54	7.51	NA	NA	0.04	XXX
78606	TC	A	Brain image w/flow 4 + views	0.00	7.35	7.28	NA	NA	0.03	XXX
78606	26	A	Brain image w/flow 4 + views	0.64	0.19	0.23	0.19	0.23	0.01	XXX
78607		A	Brain imaging (3D)	1.23	7.25	8.14	NA	NA	0.06	XXX
78607	TC	A	Brain imaging (3D)	0.00	6.94	7.71	NA	NA	0.03	XXX
78607	26	A	Brain imaging (3D)	1.23	0.31	0.43	0.31	0.43	0.03	XXX
78608		C	Brain imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78608	TC	C	Brain imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78608	26	A	Brain imaging (PET)	1.50	0.39	0.53	0.39	0.53	0.09	XXX
78609		N	Brain imaging (PET)	1.50	0.55	0.51	NA	NA	0.08	XXX
78609	TC	N	Brain imaging (PET)	0.00	0.00	0.00	NA	NA	0.00	XXX
78609	26	N	Brain imaging (PET)	1.50	0.55	0.51	0.55	0.51	0.08	XXX
78610		A	Brain flow imaging only	0.30	3.77	4.27	NA	NA	0.03	XXX
78610	TC	A	Brain flow imaging only	0.00	3.69	4.15	NA	NA	0.02	XXX
78610	26	A	Brain flow imaging only	0.30	0.08	0.12	0.08	0.12	0.01	XXX
78630		A	Cerebrospinal fluid scan	0.68	7.44	7.81	NA	NA	0.05	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	7.25	7.56	NA	NA	0.03	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.19	0.25	0.19	0.25	0.02	XXX
78635		A	CSF ventriculography	0.61	7.44	7.35	NA	NA	0.04	XXX
78635	TC	A	CSF ventriculography	0.00	7.26	7.12	NA	NA	0.03	XXX
78635	26	A	CSF ventriculography	0.61	0.18	0.23	0.18	0.23	0.01	XXX
78645		A	CSF shunt evaluation	0.57	7.15	7.36	NA	NA	0.05	XXX
78645	TC	A	CSF shunt evaluation	0.00	7.00	7.15	NA	NA	0.03	XXX
78645	26	A	CSF shunt evaluation	0.57	0.15	0.21	0.15	0.21	0.02	XXX
78647		A	Cerebrospinal fluid scan	0.90	5.87	7.58	NA	NA	0.07	XXX
78647	TC	A	Cerebrospinal fluid scan	0.00	5.75	7.30	NA	NA	0.03	XXX
78647	26	A	Cerebrospinal fluid scan	0.90	0.12	0.28	0.12	0.28	0.04	XXX
78650		A	CSF leakage imaging	0.61	7.22	7.66	NA	NA	0.06	XXX
78650	TC	A	CSF leakage imaging	0.00	7.06	7.44	NA	NA	0.03	XXX

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78650	26	A	CSF leakage imaging	0.61	0.16	0.22	0.16	0.22	0.03	XXX
78660		A	Nuclear exam of tear flow	0.53	3.77	3.84	NA	NA	0.04	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	3.60	3.64	NA	NA	0.02	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.17	0.20	0.17	0.20	0.02	XXX
78699		C	Nervous system nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78699	TC	C	Nervous system nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78699	26	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78700		A	Kidney imaging, morphol	0.45	3.63	4.02	NA	NA	0.04	XXX
78700	TC	A	Kidney imaging, morphol	0.00	3.50	3.86	NA	NA	0.02	XXX
78700	26	A	Kidney imaging, morphol	0.45	0.13	0.16	0.13	0.16	0.02	XXX
78701		A	Kidney imaging with flow	0.49	4.61	4.92	NA	NA	0.04	XXX
78701	TC	A	Kidney imaging with flow	0.00	4.47	4.75	NA	NA	0.02	XXX
78701	26	A	Kidney imaging with flow	0.49	0.14	0.17	0.14	0.17	0.02	XXX
78707		A	K flow/funct image w/o drug	0.96	4.61	5.22	NA	NA	0.05	XXX
78707	TC	A	K flow/funct image w/o drug	0.00	4.35	4.88	NA	NA	0.02	XXX
78707	26	A	K flow/funct image w/o drug	0.96	0.26	0.34	0.26	0.34	0.03	XXX
78708		A	K flow/funct image w/drug	1.21	2.81	3.65	NA	NA	0.07	XXX
78708	TC	A	K flow/funct image w/drug	0.00	2.48	3.22	NA	NA	0.03	XXX
78708	26	A	K flow/funct image w/drug	1.21	0.33	0.43	0.33	0.43	0.04	XXX
78709		A	K flow/funct image, multiple	1.41	7.53	7.93	NA	NA	0.08	XXX
78709	TC	A	K flow/funct image, multiple	0.00	7.14	7.43	NA	NA	0.03	XXX
78709	26	A	K flow/funct image, multiple	1.41	0.39	0.50	0.39	0.50	0.05	XXX
78710		A	Kidney imaging (3D)	0.66	4.14	5.23	NA	NA	0.03	XXX
78710	TC	A	Kidney imaging (3D)	0.00	3.99	5.00	NA	NA	0.02	XXX
78710	26	A	Kidney imaging (3D)	0.66	0.15	0.23	0.15	0.23	0.01	XXX
78725		A	Kidney function study	0.38	2.13	2.23	NA	NA	0.03	XXX
78725	TC	A	Kidney function study	0.00	2.01	2.10	NA	NA	0.02	XXX
78725	26	A	Kidney function study	0.38	0.12	0.13	0.12	0.13	0.01	XXX
78730		A	Urinary bladder retention	0.15	1.49	1.79	NA	NA	0.02	ZZZ
78730	TC	A	Urinary bladder retention	0.00	1.44	1.72	NA	NA	0.01	ZZZ
78730	26	A	Urinary bladder retention	0.15	0.05	0.07	0.05	0.07	0.01	ZZZ
78740		A	Ureteral reflux study	0.57	4.90	4.93	NA	NA	0.04	XXX
78740	TC	A	Ureteral reflux study	0.00	4.72	4.72	NA	NA	0.02	XXX
78740	26	A	Ureteral reflux study	0.57	0.18	0.21	0.18	0.21	0.02	XXX
78761		A	Testicular imaging w/flow	0.71	4.36	4.68	NA	NA	0.05	XXX
78761	TC	A	Testicular imaging w/flow	0.00	4.14	4.42	NA	NA	0.02	XXX
78761	26	A	Testicular imaging w/flow	0.71	0.22	0.26	0.22	0.26	0.03	XXX
78799		C	Genitourinary nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78799	TC	C	Genitourinary nuclear exam	0.00	0.00	0.00	NA	NA	0.00	XXX

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78799	26	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78800		A	Tumor imaging, limited area	0.66	3.91	4.15	NA	NA	0.04	XXX
78800	TC	A	Tumor imaging, limited area	0.00	3.71	3.92	NA	NA	0.02	XXX
78800	26	A	Tumor imaging, limited area	0.66	0.20	0.23	0.20	0.23	0.02	XXX
78801		A	Tumor imaging, mult areas	0.79	5.20	5.62	NA	NA	0.05	XXX
78801	TC	A	Tumor imaging, mult areas	0.00	4.97	5.34	NA	NA	0.02	XXX
78801	26	A	Tumor imaging, mult areas	0.79	0.23	0.28	0.23	0.28	0.03	XXX
78802		A	Tumor imaging, whole body	0.86	6.83	7.51	NA	NA	0.06	XXX
78802	TC	A	Tumor imaging, whole body	0.00	6.60	7.21	NA	NA	0.03	XXX
78802	26	A	Tumor imaging, whole body	0.86	0.23	0.30	0.23	0.30	0.03	XXX
78803		A	Tumor imaging (3D)	1.09	7.08	8.04	NA	NA	0.06	XXX
78803	TC	A	Tumor imaging (3D)	0.00	6.81	7.66	NA	NA	0.03	XXX
78803	26	A	Tumor imaging (3D)	1.09	0.27	0.38	0.27	0.38	0.03	XXX
78804		A	Tumor imaging, whole body	1.07	12.59	13.86	NA	NA	0.08	XXX
78804	TC	A	Tumor imaging, whole body	0.00	12.30	13.47	NA	NA	0.05	XXX
78804	26	A	Tumor imaging, whole body	1.07	0.29	0.39	0.29	0.39	0.03	XXX
78805		A	Abscess imaging, ltd area	0.73	3.59	4.03	NA	NA	0.04	XXX
78805	TC	A	Abscess imaging, ltd area	0.00	3.39	3.77	NA	NA	0.02	XXX
78805	26	A	Abscess imaging, ltd area	0.73	0.20	0.26	0.20	0.26	0.02	XXX
78806		A	Abscess imaging, whole body	0.86	7.06	7.85	NA	NA	0.06	XXX
78806	TC	A	Abscess imaging, whole body	0.00	6.83	7.55	NA	NA	0.03	XXX
78806	26	A	Abscess imaging, whole body	0.86	0.23	0.30	0.23	0.30	0.03	XXX
78807		A	Nuclear localization/abscess	1.09	7.00	8.04	NA	NA	0.06	XXX
78807	TC	A	Nuclear localization/abscess	0.00	6.74	7.65	NA	NA	0.03	XXX
78807	26	A	Nuclear localization/abscess	1.09	0.26	0.39	0.26	0.39	0.03	XXX
78808		A	Iv inj ra drug dx study	0.18	0.88	0.99	NA	NA	0.02	XXX
78811		C	Pet image, ltd area	0.00	0.00	0.00	NA	NA	0.00	XXX
78811	TC	C	Pet image, ltd area	0.00	0.00	0.00	NA	NA	0.00	XXX
78811	26	A	Pet image, ltd area	1.54	0.44	0.55	0.44	0.55	0.13	XXX
78812		C	Pet image, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78812	TC	C	Pet image, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78812	26	A	Pet image, skull-thigh	1.93	0.54	0.69	0.54	0.69	0.12	XXX
78813		C	Pet image, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78813	TC	C	Pet image, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78813	26	A	Pet image, full body	2.00	0.55	0.72	0.55	0.72	0.13	XXX
78814		C	Pet image w/ct, lmtd	0.00	0.00	0.00	NA	NA	0.00	XXX
78814	TC	C	Pet image w/ct, lmtd	0.00	0.00	0.00	NA	NA	0.00	XXX
78814	26	A	Pet image w/ct, lmtd	2.20	0.60	0.79	0.60	0.79	0.14	XXX
78815		C	Pet image w/ct, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX

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78815	TC	C	Pet image w/ct, skull-thigh	0.00	0.00	0.00	NA	NA	0.00	XXX
78815	26	A	Pet image w/ct, skull-thigh	2.44	0.67	0.87	0.67	0.87	0.15	XXX
78816		C	Pet image w/ct, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78816	TC	C	Pet image w/ct, full body	0.00	0.00	0.00	NA	NA	0.00	XXX
78816	26	A	Pet image w/ct, full body	2.50	0.66	0.89	0.66	0.89	0.15	XXX
78999		C	Nuclear diagnostic exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78999	TC	C	Nuclear diagnostic exam	0.00	0.00	0.00	NA	NA	0.00	XXX
78999	26	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79005		A	Nuclear rx, oral admin	1.80	1.61	2.12	NA	NA	0.06	XXX
79005	TC	A	Nuclear rx, oral admin	0.00	1.07	1.49	NA	NA	0.01	XXX
79005	26	A	Nuclear rx, oral admin	1.80	0.54	0.63	0.54	0.63	0.05	XXX
79101		A	Nuclear rx, iv admin	1.96	1.88	2.46	NA	NA	0.05	XXX
79101	TC	A	Nuclear rx, iv admin	0.00	1.14	1.62	NA	NA	0.01	XXX
79101	26	A	Nuclear rx, iv admin	1.96	0.74	0.84	0.74	0.84	0.04	XXX
79200		A	Nuclear rx, intracav admin	1.99	2.04	2.53	NA	NA	0.09	XXX
79200	TC	A	Nuclear rx, intracav admin	0.00	1.42	1.80	NA	NA	0.01	XXX
79200	26	A	Nuclear rx, intracav admin	1.99	0.62	0.73	0.62	0.73	0.08	XXX
79300		C	Nuclr rx, interstit colloid	0.00	0.00	0.00	NA	NA	0.00	XXX
79300	TC	C	Nuclr rx, interstit colloid	0.00	0.00	0.00	NA	NA	0.00	XXX
79300	26	A	Nuclr rx, interstit colloid	1.60	0.48	0.56	0.48	0.56	0.11	XXX
79403		A	Hematopoietic nuclear tx	2.25	2.48	3.36	NA	NA	0.10	XXX
79403	TC	A	Hematopoietic nuclear tx	0.00	1.81	2.53	NA	NA	0.02	XXX
79403	26	A	Hematopoietic nuclear tx	2.25	0.67	0.83	0.67	0.83	0.08	XXX
79440		A	Nuclear rx, intra-articular	1.99	1.64	2.15	NA	NA	0.05	XXX
79440	TC	A	Nuclear rx, intra-articular	0.00	1.02	1.42	NA	NA	0.01	XXX
79440	26	A	Nuclear rx, intra-articular	1.99	0.62	0.73	0.62	0.73	0.04	XXX
79445		C	Nuclear rx, intra-arterial	0.00	0.00	0.00	NA	NA	0.00	XXX
79445	TC	C	Nuclear rx, intra-arterial	0.00	0.00	0.00	NA	NA	0.00	XXX
79445	26	A	Nuclear rx, intra-arterial	2.40	0.64	0.86	0.64	0.86	0.14	XXX
79999		C	Nuclear medicine therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
79999	TC	C	Nuclear medicine therapy	0.00	0.00	0.00	NA	NA	0.00	XXX
79999	26	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
80500		A	Lab pathology consultation	0.37	0.17	0.19	0.11	0.12	0.02	XXX
80502		A	Lab pathology consultation	1.33	0.40	0.42	0.35	0.37	0.06	XXX
83020	26	A	Hemoglobin electrophoresis	0.37	0.15	0.14	0.15	0.14	0.02	XXX
83912	26	A	Genetic examination	0.37	0.13	0.12	0.13	0.12	0.02	XXX
84165	26	A	Protein e-phoresis, serum	0.37	0.14	0.13	0.14	0.13	0.02	XXX
84166	26	A	Protein e-phoresis/urine/csf	0.37	0.14	0.13	0.14	0.13	0.02	XXX
84181	26	A	Western blot test	0.37	0.15	0.13	0.15	0.13	0.02	XXX

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84182	26	A	Protein, western blot test	0.37	0.15	0.14	0.15	0.14	0.02	XXX
85060		A	Blood smear interpretation	0.45	0.17	0.16	0.17	0.16	0.02	XXX
85097		A	Bone marrow interpretation	0.94	1.14	1.36	0.32	0.32	0.04	XXX
85390	26	A	Fibrinolysins screen	0.37	0.15	0.14	0.15	0.14	0.02	XXX
85396		A	Clotting assay, whole blood	0.37	NA	NA	0.13	0.12	0.02	XXX
85576	26	A	Blood platelet aggregation	0.37	0.15	0.14	0.15	0.14	0.02	XXX
86077		A	Physician blood bank service	0.94	0.44	0.40	0.36	0.34	0.04	XXX
86078		A	Physician blood bank service	0.94	0.45	0.42	0.37	0.34	0.04	XXX
86079		A	Physician blood bank service	0.94	0.45	0.43	0.37	0.35	0.04	XXX
86255	26	A	Fluorescent antibody, screen	0.37	0.15	0.14	0.15	0.14	0.02	XXX
86256	26	A	Fluorescent antibody, titer	0.37	0.14	0.14	0.14	0.14	0.02	XXX
86320	26	A	Serum immunoelectrophoresis	0.37	0.14	0.14	0.14	0.14	0.01	XXX
86325	26	A	Other immunoelectrophoresis	0.37	0.14	0.13	0.14	0.13	0.02	XXX
86327	26	A	Immunoelectrophoresis assay	0.42	0.16	0.16	0.16	0.16	0.02	XXX
86334	26	A	Immunofix e-phoresis, serum	0.37	0.14	0.14	0.14	0.14	0.02	XXX
86335	26	A	Immunfix e-phorsis/urine/csf	0.37	0.14	0.13	0.14	0.13	0.02	XXX
86485		C	Skin test, candida	0.00	0.00	0.00	0.00	0.00	0.00	XXX
86486		A	Skin test, nos antigen	0.00	0.11	0.12	NA	NA	0.01	XXX
86490		A	Coccidioidomycosis skin test	0.00	0.11	0.16	NA	NA	0.01	XXX
86510		A	Histoplasmosis skin test	0.00	0.13	0.16	NA	NA	0.01	XXX
86580		A	TB intradermal test	0.00	0.17	0.18	NA	NA	0.01	XXX
87164	26	A	Dark field examination	0.37	0.15	0.13	0.15	0.13	0.02	XXX
87207	26	A	Smear, special stain	0.37	0.15	0.14	0.15	0.14	0.02	XXX
88104		A	Cytopath fl nongyn, smears	0.56	1.12	1.11	NA	NA	0.02	XXX
88104	TC	A	Cytopath fl nongyn, smears	0.00	0.92	0.92	NA	NA	0.01	XXX
88104	26	A	Cytopath fl nongyn, smears	0.56	0.20	0.19	0.20	0.19	0.01	XXX
88106		A	Cytopath fl nongyn, filter	0.56	1.48	1.52	NA	NA	0.02	XXX
88106	TC	A	Cytopath fl nongyn, filter	0.00	1.28	1.33	NA	NA	0.01	XXX
88106	26	A	Cytopath fl nongyn, filter	0.56	0.20	0.19	0.20	0.19	0.01	XXX
88107		A	Cytopath fl nongyn, sm/fltr	0.76	1.86	1.86	NA	NA	0.02	XXX
88107	TC	A	Cytopath fl nongyn, sm/fltr	0.00	1.58	1.59	NA	NA	0.01	XXX
88107	26	A	Cytopath fl nongyn, sm/fltr	0.76	0.28	0.27	0.28	0.27	0.01	XXX
88108		A	Cytopath, concentrate tech	0.56	1.31	1.38	NA	NA	0.02	XXX
88108	TC	A	Cytopath, concentrate tech	0.00	1.12	1.20	NA	NA	0.01	XXX
88108	26	A	Cytopath, concentrate tech	0.56	0.19	0.18	0.19	0.18	0.01	XXX
88112		A	Cytopath, cell enhance tech	1.18	1.36	1.54	NA	NA	0.04	XXX
88112	TC	A	Cytopath, cell enhance tech	0.00	1.00	1.18	NA	NA	0.01	XXX
88112	26	A	Cytopath, cell enhance tech	1.18	0.36	0.36	0.36	0.36	0.03	XXX
88125		A	Forensic cytopathology	0.26	0.30	0.31	NA	NA	0.02	XXX

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88125	TC	A	Forensic cytopathology	0.00	0.20	0.22	NA	NA	0.01	XXX
88125	26	A	Forensic cytopathology	0.26	0.10	0.09	0.10	0.09	0.01	XXX
88141		A	Cytopath, c/v, interpret	0.42	0.34	0.32	0.34	0.32	0.02	XXX
88160		A	Cytopath smear, other source	0.50	0.83	0.88	NA	NA	0.02	XXX
88160	TC	A	Cytopath smear, other source	0.00	0.67	0.72	NA	NA	0.01	XXX
88160	26	A	Cytopath smear, other source	0.50	0.16	0.16	0.16	0.16	0.01	XXX
88161		A	Cytopath smear, other source	0.50	0.83	0.93	NA	NA	0.02	XXX
88161	TC	A	Cytopath smear, other source	0.00	0.68	0.78	NA	NA	0.01	XXX
88161	26	A	Cytopath smear, other source	0.50	0.15	0.15	0.15	0.15	0.01	XXX
88162		A	Cytopath smear, other source	0.76	0.98	1.26	NA	NA	0.02	XXX
88162	TC	A	Cytopath smear, other source	0.00	0.79	1.02	NA	NA	0.01	XXX
88162	26	A	Cytopath smear, other source	0.76	0.19	0.24	0.19	0.24	0.01	XXX
88172		A	Cytopathology eval of fna	0.60	0.84	0.82	NA	NA	0.02	XXX
88172	TC	A	Cytopathology eval of fna	0.00	0.61	0.61	NA	NA	0.01	XXX
88172	26	A	Cytopathology eval of fna	0.60	0.23	0.21	0.23	0.21	0.01	XXX
88173		A	Cytopath eval, fna, report	1.39	2.11	2.21	NA	NA	0.04	XXX
88173	TC	A	Cytopath eval, fna, report	0.00	1.63	1.74	NA	NA	0.01	XXX
88173	26	A	Cytopath eval, fna, report	1.39	0.48	0.47	0.48	0.47	0.03	XXX
88182		A	Cell marker study	0.77	1.75	1.94	NA	NA	0.03	XXX
88182	TC	A	Cell marker study	0.00	1.58	1.76	NA	NA	0.02	XXX
88182	26	A	Cell marker study	0.77	0.17	0.18	0.17	0.18	0.01	XXX
88184		A	Flowcytometry/ tc, 1 marker	0.00	1.96	2.14	NA	NA	0.01	XXX
88185		A	Flowcytometry/tc, add-on	0.00	1.19	1.27	NA	NA	0.01	ZZZ
88187		A	Flowcytometry/read, 2-8	1.36	0.47	0.43	0.47	0.43	0.06	XXX
88188		A	Flowcytometry/read, 9-15	1.69	0.59	0.52	0.59	0.52	0.08	XXX
88189		A	Flowcytometry/read, 16 & >	2.23	0.56	0.56	0.56	0.56	0.10	XXX
88199		C	Cytopathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88199	TC	C	Cytopathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88199	26	C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88291		A	Cyto/molecular report	0.52	0.25	0.25	0.25	0.25	0.02	XXX
88299		C	Cytogenetic study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88300		A	Surgical path, gross	0.08	0.53	0.55	NA	NA	0.02	XXX
88300	TC	A	Surgical path, gross	0.00	0.50	0.52	NA	NA	0.01	XXX
88300	26	A	Surgical path, gross	0.08	0.03	0.03	0.03	0.03	0.01	XXX
88302		A	Tissue exam by pathologist	0.13	1.15	1.19	NA	NA	0.02	XXX
88302	TC	A	Tissue exam by pathologist	0.00	1.10	1.15	NA	NA	0.01	XXX
88302	26	A	Tissue exam by pathologist	0.13	0.05	0.04	0.05	0.04	0.01	XXX
88304		A	Tissue exam by pathologist	0.22	1.36	1.45	NA	NA	0.02	XXX
88304	TC	A	Tissue exam by pathologist	0.00	1.28	1.38	NA	NA	0.01	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
88304	26	A	Tissue exam by pathologist	0.22	0.08	0.07	0.08	0.07	0.01	XXX
88305		A	Tissue exam by pathologist	0.75	1.87	2.05	NA	NA	0.02	XXX
88305	TC	A	Tissue exam by pathologist	0.00	1.62	1.79	NA	NA	0.01	XXX
88305	26	A	Tissue exam by pathologist	0.75	0.25	0.26	0.25	0.26	0.01	XXX
88307		A	Tissue exam by pathologist	1.59	4.17	4.15	NA	NA	0.05	XXX
88307	TC	A	Tissue exam by pathologist	0.00	3.58	3.59	NA	NA	0.02	XXX
88307	26	A	Tissue exam by pathologist	1.59	0.59	0.56	0.59	0.56	0.03	XXX
88309		A	Tissue exam by pathologist	2.80	6.04	5.90	NA	NA	0.07	XXX
88309	TC	A	Tissue exam by pathologist	0.00	4.99	4.95	NA	NA	0.02	XXX
88309	26	A	Tissue exam by pathologist	2.80	1.05	0.95	1.05	0.95	0.05	XXX
88311		A	Decalcify tissue	0.24	0.25	0.24	NA	NA	0.02	XXX
88311	TC	A	Decalcify tissue	0.00	0.16	0.16	NA	NA	0.01	XXX
88311	26	A	Decalcify tissue	0.24	0.09	0.08	0.09	0.08	0.01	XXX
88312		A	Special stains group 1	0.54	2.10	2.16	NA	NA	0.02	XXX
88312	TC	A	Special stains group 1	0.00	1.92	1.99	NA	NA	0.01	XXX
88312	26	A	Special stains group 1	0.54	0.18	0.17	0.18	0.17	0.01	XXX
88313		A	Special stains group 2	0.24	1.63	1.73	NA	NA	0.02	XXX
88313	TC	A	Special stains group 2	0.00	1.56	1.66	NA	NA	0.01	XXX
88313	26	A	Special stains group 2	0.24	0.07	0.07	0.07	0.07	0.01	XXX
88314		A	Histochemical stain add-on	0.45	1.69	1.90	NA	NA	0.02	XXX
88314	TC	A	Histochemical stain add-on	0.00	1.52	1.74	NA	NA	0.01	XXX
88314	26	A	Histochemical stain add-on	0.45	0.17	0.16	0.17	0.16	0.01	XXX
88318		A	Chemical histochemistry	0.42	2.09	2.26	NA	NA	0.02	XXX
88318	TC	A	Chemical histochemistry	0.00	1.97	2.13	NA	NA	0.01	XXX
88318	26	A	Chemical histochemistry	0.42	0.12	0.13	0.12	0.13	0.01	XXX
88319		A	Enzyme histochemistry	0.53	2.94	3.20	NA	NA	0.03	XXX
88319	TC	A	Enzyme histochemistry	0.00	2.75	3.02	NA	NA	0.02	XXX
88319	26	A	Enzyme histochemistry	0.53	0.19	0.18	0.19	0.18	0.01	XXX
88321		A	Microslide consultation	1.63	0.79	0.76	0.57	0.53	0.07	XXX
88323		A	Microslide consultation	1.83	1.85	2.01	NA	NA	0.04	XXX
88323	TC	A	Microslide consultation	0.00	1.35	1.52	NA	NA	0.01	XXX
88323	26	A	Microslide consultation	1.83	0.50	0.49	0.50	0.49	0.03	XXX
88325		A	Comprehensive review of data	2.50	2.73	2.71	1.01	0.88	0.10	XXX
88329		A	Path consult introp	0.67	0.68	0.68	0.25	0.24	0.03	XXX
88331		A	Path consult intraop, 1 bloc	1.19	1.23	1.22	NA	NA	0.02	XXX
88331	TC	A	Path consult intraop, 1 bloc	0.00	0.77	0.78	NA	NA	0.01	XXX
88331	26	A	Path consult intraop, 1 bloc	1.19	0.46	0.44	0.46	0.44	0.01	XXX
88332		A	Path consult intraop, addl	0.59	0.48	0.48	NA	NA	0.02	XXX
88332	TC	A	Path consult intraop, addl	0.00	0.26	0.27	NA	NA	0.01	XXX

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88332	26	A	Path consult intraop, addl	0.59	0.22	0.21	0.22	0.21	0.01	XXX
88333		A	Intraop cyto path consult, 1	1.20	1.32	1.28	NA	NA	0.03	XXX
88333	TC	A	Intraop cyto path consult, 1	0.00	0.87	0.85	NA	NA	0.01	XXX
88333	26	A	Intraop cyto path consult, 1	1.20	0.45	0.43	0.45	0.43	0.02	XXX
88334		A	Intraop cyto path consult, 2	0.73	0.82	0.78	NA	NA	0.02	XXX
88334	TC	A	Intraop cyto path consult, 2	0.00	0.54	0.53	NA	NA	0.01	XXX
88334	26	A	Intraop cyto path consult, 2	0.73	0.28	0.25	0.28	0.25	0.01	XXX
88342		A	Immunohistochemistry	0.85	1.78	1.84	NA	NA	0.03	XXX
88342	TC	A	Immunohistochemistry	0.00	1.51	1.57	NA	NA	0.01	XXX
88342	26	A	Immunohistochemistry	0.85	0.27	0.27	0.27	0.27	0.02	XXX
88346		A	Immunofluorescent study	0.86	1.70	1.82	NA	NA	0.02	XXX
88346	TC	A	Immunofluorescent study	0.00	1.42	1.54	NA	NA	0.01	XXX
88346	26	A	Immunofluorescent study	0.86	0.28	0.28	0.28	0.28	0.01	XXX
88347		A	Immunofluorescent study	0.86	1.11	1.23	NA	NA	0.02	XXX
88347	TC	A	Immunofluorescent study	0.00	0.90	1.01	NA	NA	0.01	XXX
88347	26	A	Immunofluorescent study	0.86	0.21	0.22	0.21	0.22	0.01	XXX
88348		A	Electron microscopy	1.51	14.87	15.59	NA	NA	0.10	XXX
88348	TC	A	Electron microscopy	0.00	14.39	15.10	NA	NA	0.07	XXX
88348	26	A	Electron microscopy	1.51	0.48	0.49	0.48	0.49	0.03	XXX
88349		A	Scanning electron microscopy	0.76	8.75	7.79	NA	NA	0.03	XXX
88349	TC	A	Scanning electron microscopy	0.00	8.45	7.52	NA	NA	0.01	XXX
88349	26	A	Scanning electron microscopy	0.76	0.30	0.27	0.30	0.27	0.02	XXX
88355		A	Analysis, skeletal muscle	1.85	2.60	4.15	NA	NA	0.06	XXX
88355	TC	A	Analysis, skeletal muscle	0.00	2.20	3.68	NA	NA	0.02	XXX
88355	26	A	Analysis, skeletal muscle	1.85	0.40	0.47	0.40	0.47	0.04	XXX
88356		A	Analysis, nerve	3.02	3.93	4.61	NA	NA	0.13	XXX
88356	TC	A	Analysis, nerve	0.00	3.44	3.96	NA	NA	0.04	XXX
88356	26	A	Analysis, nerve	3.02	0.49	0.65	0.49	0.65	0.09	XXX
88358		A	Analysis, tumor	0.95	0.95	1.03	NA	NA	0.03	XXX
88358	TC	A	Analysis, tumor	0.00	0.76	0.81	NA	NA	0.01	XXX
88358	26	A	Analysis, tumor	0.95	0.19	0.22	0.19	0.22	0.02	XXX
88360		A	Tumor immunohistochem/manual	1.10	2.05	2.13	NA	NA	0.03	XXX
88360	TC	A	Tumor immunohistochem/manual	0.00	1.71	1.79	NA	NA	0.01	XXX
88360	26	A	Tumor immunohistochem/manual	1.10	0.34	0.34	0.34	0.34	0.02	XXX
88361		A	Tumor immunohistochem/comput	1.18	2.45	2.78	NA	NA	0.03	XXX
88361	TC	A	Tumor immunohistochem/comput	0.00	2.12	2.44	NA	NA	0.01	XXX
88361	26	A	Tumor immunohistochem/comput	1.18	0.33	0.34	0.33	0.34	0.02	XXX
88362		A	Nerve teasing preparations	2.17	5.10	5.01	NA	NA	0.11	XXX
88362	TC	A	Nerve teasing preparations	0.00	4.34	4.30	NA	NA	0.04	XXX
88362	26	A	Nerve teasing preparations	2.17	0.76	0.71	0.76	0.71	0.07	XXX
88365		A	Insitu hybridization (fish)	1.20	3.00	3.08	NA	NA	0.03	XXX
88365	TC	A	Insitu hybridization (fish)	0.00	2.63	2.71	NA	NA	0.01	XXX
88365	26	A	Insitu hybridization (fish)	1.20	0.37	0.37	0.37	0.37	0.02	XXX
88367		A	Insitu hybridization, auto	1.30	4.83	5.16	NA	NA	0.05	XXX
88367	TC	A	Insitu hybridization, auto	0.00	4.50	4.81	NA	NA	0.01	XXX
88367	26	A	Insitu hybridization, auto	1.30	0.33	0.35	0.33	0.35	0.04	XXX
88368		A	Insitu hybridization, manual	1.40	3.99	4.27	NA	NA	0.04	XXX
88368	TC	A	Insitu hybridization, manual	0.00	3.72	3.94	NA	NA	0.01	XXX
88368	26	A	Insitu hybridization, manual	1.40	0.27	0.33	0.27	0.33	0.03	XXX
88371	26	A	Protein, western blot tissue	0.37	0.15	0.13	0.15	0.13	0.02	XXX
88372	26	A	Protein analysis w/probe	0.37	0.14	0.13	0.14	0.13	0.02	XXX
88380		A	Microdissection, laser	1.56	3.50	3.70	NA	NA	0.04	XXX
88380	TC	A	Microdissection, laser	0.00	2.91	3.17	NA	NA	0.01	XXX
88380	26	A	Microdissection, laser	1.56	0.59	0.53	0.59	0.53	0.03	XXX
88381		A	Microdissection, manual	1.18	2.37	4.12	NA	NA	0.04	XXX
88381	TC	A	Microdissection, manual	0.00	2.17	3.78	NA	NA	0.02	XXX
88381	26	A	Microdissection, manual	1.18	0.20	0.34	0.20	0.34	0.02	XXX
88384		C	Eval molecular probes, 11-50	0.00	0.00	0.00	NA	NA	0.00	XXX
88384	TC	C	Eval molecular probes, 11-50	0.00	0.00	0.00	NA	NA	0.00	XXX
88384	26	C	Eval molecular probes, 11-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88385		A	Eval molecul probes, 51-250	1.50	22.61	15.46	NA	NA	0.06	XXX
88385	TC	A	Eval molecul probes, 51-250	0.00	22.02	15.05	NA	NA	0.03	XXX
88385	26	A	Eval molecul probes, 51-250	1.50	0.59	0.41	0.59	0.41	0.03	XXX
88386		A	Eval molecul probes, 251-500	1.88	13.72	15.96	NA	NA	0.07	XXX
88386	TC	A	Eval molecul probes, 251-500	0.00	13.21	15.28	NA	NA	0.03	XXX
88386	26	A	Eval molecul probes, 251-500	1.88	0.51	0.68	0.51	0.68	0.04	XXX
88387		A	Tiss exam molecular study	0.62	0.45	0.45	NA	NA	0.02	XXX
88387	TC	A	Tiss exam molecular study	0.00	0.21	0.21	NA	NA	0.01	XXX
88387	26	A	Tiss exam molecular study	0.62	0.24	0.24	0.24	0.24	0.01	XXX
88388		A	Tiss ex molecul study add-on	0.45	0.18	0.18	NA	NA	0.02	XXX
88388	TC	A	Tiss ex molecul study add-on	0.00	0.10	0.10	NA	NA	0.01	XXX
88388	26	A	Tiss ex molecul study add-on	0.45	0.08	0.08	0.08	0.08	0.01	XXX
88399		C	Surgical pathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX

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88399	TC	C	Surgical pathology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
88399	26	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
89049		A	Chct for mal hyperthermia	1.40	4.94	5.12	0.37	0.41	0.08	XXX
89060	26	A	Exam.synovial fluid crystals	0.37	0.14	0.14	0.14	0.14	0.02	XXX
89100		A	Sample intestinal contents	0.60	7.55	6.49	0.53	0.47	0.03	XXX
89105		A	Sample intestinal contents	0.50	6.76	6.51	0.43	0.41	0.02	XXX
89130		A	Sample stomach contents	0.45	6.26	5.62	0.39	0.34	0.02	XXX
89132		A	Sample stomach contents	0.19	6.33	6.46	0.30	0.30	0.01	XXX
89135		A	Sample stomach contents	0.79	7.53	7.26	0.60	0.60	0.04	XXX
89136		A	Sample stomach contents	0.21	6.31	5.67	0.30	0.27	0.01	XXX
89140		A	Sample stomach contents	0.94	6.70	5.92	0.57	0.49	0.05	XXX
89141		A	Sample stomach contents	0.85	6.66	6.15	0.54	0.50	0.04	XXX
89220		A	Sputum specimen collection	0.00	0.37	0.39	NA	NA	0.01	XXX
89230		A	Collect sweat for test	0.00	0.15	0.11	NA	NA	0.01	XXX
89240		C	Pathology lab procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90281		I	Human ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90283		I	Human ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90284		X	Human ig, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90287		I	Botulinum antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90288		I	Botulism ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90291		I	Cmv ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90296		E	Diphtheria antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90371		E	Hep b ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90375		E	Rabies ig, im/sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90376		E	Rabies ig, heat treated	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90378		X	Rsv, mab, im, 50mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90384		I	Rh ig, full-dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90385		E	Rh ig, minidose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90386		I	Rh ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90389		I	Tetanus ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90393		E	Vaccina ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90396		E	Varicella-zoster ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90399		I	Immune globulin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90465		A	Immune admin 1 inj, < 8 yrs	0.17	0.42	0.41	NA	NA	0.01	XXX
90466		A	Immune admin addl inj, < 8 y	0.15	0.16	0.14	0.06	0.06	0.01	ZZZ
90467		R	Immune admin o or n, < 8 yrs	0.17	0.26	0.22	0.10	0.09	0.01	XXX
90468		R	Immune admin o/n, addl < 8 y	0.15	0.15	0.13	0.06	0.05	0.01	ZZZ
90470		N	Immune admin H1N1 im/nasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90471		A	Immunization admin	0.17	0.42	0.41	NA	NA	0.01	XXX

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90472		A	Immunization admin, each add	0.15	0.16	0.14	0.06	0.06	0.01	ZZZ
90473		R	Immune admin oral/nasal	0.17	0.26	0.22	0.07	0.05	0.01	XXX
90474		R	Immune admin oral/nasal addl	0.15	0.11	0.10	0.06	0.05	0.01	ZZZ
90476		E	Adenovirus vaccine, type 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90477		E	Adenovirus vaccine, type 7	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90581		E	Anthrax vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90585		E	Bcg vaccine, percut	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90586		E	Bcg vaccine, intravesical	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90632		E	Hep a vaccine, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90633		E	Hep a vacc, ped/adol, 2 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90634		E	Hep a vacc, ped/adol, 3 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90636		E	Hep a/hep b vacc, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90644		X	HIB/men/tt vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90645		E	Hib vaccine, hboc, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90646		E	Hib vaccine, prp-d, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90647		E	Hib vaccine, prp-omp, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90648		E	Hib vaccine, prp-t, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90649		E	Hpv vaccine 4 valent, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90650		E	Hpv vaccine 2 valent, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90655		X	Flu vaccine no preserv 6-35m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90656		X	Flu vaccine no preserv 3 & >	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90657		X	Flu vaccine, 3 yrs, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90658		X	Flu vaccine, 3 yrs & >, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90660		X	Flu vaccine, nasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90661		X	Flu vacc cell cult prsv free	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90662		X	Flu vacc prsv free inc antig	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90663		X	Flu vacc pandemic H1N1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90665		E	Lyme disease vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90669		X	Pneumococcal vacc, 7 val im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90670		X	Pneumococcal vacc, 13 val im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90675		E	Rabies vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90676		E	Rabies vaccine, id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90680		E	Rotovirus vacc 3 dose, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90681		E	Rotavirus vacc 2 dose oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90690		E	Typhoid vaccine, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90691		E	Typhoid vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90692		E	Typhoid vaccine, h-p, sc/id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90693		E	Typhoid vaccine, akd, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90696		E	Dtap-ipv vacc 4-6 yr im	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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90698		E	Dtap-hib-ip vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90700		E	Dtap vaccine, < 7 yrs, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90701		E	Dtp vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90702		E	Dt vaccine < 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90703		E	Tetanus vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90704		E	Mumps vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90705		E	Measles vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90706		E	Rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90707		E	Mmr vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90708		E	Measles-rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90710		E	Mmrv vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90712		E	Oral poliovirus vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90713		E	Poliovirus, ipv, sc/im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90714		E	Td vaccine no prsrv >/= 7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90715		E	Tdap vaccine >7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90716		E	Chicken pox vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90717		E	Yellow fever vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90718		E	Td vaccine > 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90719		E	Diphtheria vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90720		E	Dtp/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90721		E	Dtap/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90723		I	Dtap-hep b-ipv vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90725		E	Cholera vaccine, injectable	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90727		E	Plague vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90732		X	Pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90733		E	Meningococcal vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90734		E	Meningococcal vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90735		E	Encephalitis vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90736		E	Zoster vacc, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90738		I	Inactivated je vacc im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90740		X	Hepb vacc, ill pat 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90743		X	Hep b vacc, adol, 2 dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90744		X	Hepb vacc ped/adol 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90746		X	Hep b vaccine, adult, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90747		X	Hepb vacc, ill pat 4 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90748		I	Hep b/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90749		E	Vaccine toxoid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90801		A	Psy dx interview	2.80	1.30	1.38	0.50	0.65	0.08	XXX
90802		A	Intac psy dx interview	3.01	1.47	1.47	0.59	0.71	0.10	XXX

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90804		A	Psytx, office, 20-30 min	1.21	0.47	0.52	0.15	0.24	0.04	XXX
90805		A	Psytx, off, 20-30 min w/e&m	1.37	0.58	0.58	0.23	0.28	0.04	XXX
90806		A	Psytx, off, 45-50 min	1.86	0.38	0.53	0.20	0.36	0.05	XXX
90807		A	Psytx, off, 45-50 min w/e&m	2.02	0.68	0.71	0.34	0.41	0.07	XXX
90808		A	Psytx, office, 75-80 min	2.79	0.49	0.72	0.31	0.54	0.08	XXX
90809		A	Psytx, off, 75-80, w/e&m	2.95	0.84	0.90	0.52	0.62	0.10	XXX
90810		A	Intac psytx, off, 20-30 min	1.32	0.43	0.51	0.17	0.26	0.04	XXX
90811		A	Intac psytx, 20-30, w/e&m	1.48	0.70	0.69	0.26	0.31	0.05	XXX
90812		A	Intac psytx, off, 45-50 min	1.97	0.48	0.64	0.21	0.38	0.05	XXX
90813		A	Intac psytx, 45-50 min w/e&m	2.13	0.80	0.82	0.35	0.44	0.07	XXX
90814		A	Intac psytx, off, 75-80 min	2.90	0.64	0.88	0.32	0.62	0.09	XXX
90815		A	Intac psytx, 75-80 w/e&m	3.06	1.00	1.02	0.54	0.64	0.10	XXX
90816		A	Psytx, hosp, 20-30 min	1.25	NA	NA	0.22	0.33	0.03	XXX
90817		A	Psytx, hosp, 20-30 min w/e&m	1.41	NA	NA	0.34	0.38	0.05	XXX
90818		A	Psytx, hosp, 45-50 min	1.89	NA	NA	0.28	0.46	0.05	XXX
90819		A	Psytx, hosp, 45-50 min w/e&m	2.05	NA	NA	0.45	0.51	0.07	XXX
90821		A	Psytx, hosp, 75-80 min	2.83	NA	NA	0.40	0.64	0.08	XXX
90822		A	Psytx, hosp, 75-80 min w/e&m	2.99	NA	NA	0.60	0.70	0.10	XXX
90823		A	Intac psytx, hosp, 20-30 min	1.36	NA	NA	0.22	0.34	0.04	XXX
90824		A	Intac psytx, hsp 20-30 w/e&m	1.52	NA	NA	0.35	0.40	0.05	XXX
90826		A	Intac psytx, hosp, 45-50 min	2.01	NA	NA	0.30	0.48	0.05	XXX
90827		A	Intac psytx, hsp 45-50 w/e&m	2.16	NA	NA	0.46	0.53	0.07	XXX
90828		A	Intac psytx, hosp, 75-80 min	2.94	NA	NA	0.38	0.66	0.08	XXX
90829		A	Intac psytx, hsp 75-80 w/e&m	3.10	NA	NA	0.61	0.72	0.10	XXX
90845		A	Psychoanalysis	1.79	0.39	0.43	0.33	0.38	0.06	XXX
90846		R	Family psytx w/o patient	1.83	0.41	0.52	0.33	0.46	0.05	XXX
90847		R	Family psytx w/patient	2.21	0.58	0.72	0.36	0.53	0.06	XXX
90849		R	Multiple family group psytx	0.59	0.30	0.30	0.18	0.21	0.02	XXX
90853		A	Group psychotherapy	0.59	0.27	0.27	0.20	0.21	0.02	XXX
90857		A	Intac group psytx	0.63	0.32	0.33	0.19	0.22	0.02	XXX
90862		A	Medication management	0.95	0.61	0.58	0.27	0.28	0.03	XXX
90865		A	Narcosynthesis	2.84	1.46	1.38	0.57	0.70	0.09	XXX
90870		A	Electroconvulsive therapy	1.88	1.85	1.90	0.37	0.43	0.06	000
90875		N	Psychophysiological therapy	1.20	0.70	0.74	0.44	0.43	0.06	XXX
90876		N	Psychophysiological therapy	1.90	0.94	0.97	0.69	0.68	0.10	XXX
90880		A	Hypnotherapy	2.19	0.41	0.64	0.28	0.44	0.06	XXX
90882		N	Environmental manipulation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90885		B	Psy evaluation of records	0.97	0.35	0.35	0.35	0.35	0.05	XXX
90887		B	Consultation with family	1.48	0.83	0.82	0.54	0.53	0.07	XXX

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90889		B	Preparation of report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90899		C	Psychiatric service/therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90901		A	Biofeedback train, any meth	0.41	0.54	0.52	0.13	0.12	0.02	000
90911		A	Biofeedback peri/uro/rectal	0.89	1.22	1.40	0.30	0.32	0.05	000
90935		A	Hemodialysis, one evaluation	1.22	NA	NA	0.63	0.60	0.05	000
90937		A	Hemodialysis, repeated eval	2.11	NA	NA	0.93	0.88	0.09	000
90940		X	Hemodialysis access study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90945		A	Dialysis, one evaluation	1.28	NA	NA	0.65	0.62	0.05	000
90947		A	Dialysis, repeated eval	2.16	NA	NA	0.94	0.89	0.09	000
90951		A	Esrd serv, 4 visits p mo, <2	18.46	8.37	7.92	8.37	7.92	0.93	XXX
90952		C	Esrd serv, 2-3 vsts p mo, <2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90953		C	Esrd serv, 1 visit p mo, <2	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90954		A	Esrd serv, 4 vsts p mo, 2-11	15.98	6.54	5.71	6.54	5.71	0.80	XXX
90955		A	Esrd srv 2-3 vsts p mo, 2-11	8.79	3.67	3.44	3.67	3.44	0.44	XXX
90956		A	Esrd srv, 1 visit p mo, 2-11	5.95	2.28	2.29	2.28	2.29	0.30	XXX
90957		A	Esrd srv, 4 vsts p mo, 12-19	12.52	5.51	4.92	5.51	4.92	0.63	XXX
90958		A	Esrd srv 2-3 vsts p mo 12-19	8.34	3.62	3.38	3.62	3.38	0.42	XXX
90959		A	Esrd serv, 1 vst p mo, 12-19	5.50	2.14	2.14	2.14	2.14	0.28	XXX
90960		A	Esrd srv, 4 visits p mo, 20+	5.18	2.68	2.56	2.68	2.56	0.26	XXX
90961		A	Esrd srv, 2-3 vsts p mo, 20+	4.26	2.02	1.96	2.02	1.96	0.21	XXX
90962		A	Esrd serv, 1 visit p mo, 20+	3.15	1.30	1.32	1.30	1.32	0.16	XXX
90963		A	Esrd home pt, serv p mo, <2	10.56	4.06	4.19	4.06	4.19	0.53	XXX
90964		A	Esrd home pt serv p mo, 2-11	9.14	3.60	3.26	3.60	3.26	0.46	XXX
90965		A	Esrd home pt serv p mo 12-19	8.69	3.46	3.13	3.46	3.13	0.44	XXX
90966		A	Esrd home pt, serv p mo, 20+	4.26	2.11	1.93	2.11	1.93	0.21	XXX
90967		A	Esrd home pt serv p day, <2	0.35	0.19	0.19	0.19	0.19	0.02	XXX
90968		A	Esrd home pt srv p day, 2-11	0.30	0.13	0.12	0.13	0.12	0.02	XXX
90969		A	Esrd home pt srv p day 12-19	0.29	0.13	0.12	0.13	0.12	0.01	XXX
90970		A	Esrd home pt serv p day, 20+	0.14	0.07	0.07	0.07	0.07	0.01	XXX
90989		X	Dialysis training, complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90993		X	Dialysis training, incompl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90997		A	Hemoperfusion	1.84	NA	NA	0.60	0.58	0.08	000
90999		C	Dialysis procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91000		A	Esophageal intubation	0.73	2.12	1.79	NA	NA	0.03	000
91000	TC	A	Esophageal intubation	0.00	1.85	1.54	NA	NA	0.01	000
91000	26	A	Esophageal intubation	0.73	0.27	0.25	0.27	0.25	0.02	000
91010		A	Esophagus motility study	1.25	3.21	3.68	NA	NA	0.06	000
91010	TC	A	Esophagus motility study	0.00	2.67	3.13	NA	NA	0.01	000
91010	26	A	Esophagus motility study	1.25	0.54	0.55	0.54	0.55	0.05	000

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91011		A	Esophagus motility study	1.50	4.51	5.13	NA	NA	0.05	000
91011	TC	A	Esophagus motility study	0.00	3.85	4.43	NA	NA	0.01	000
91011	26	A	Esophagus motility study	1.50	0.66	0.70	0.66	0.70	0.04	000
91012		A	Esophagus motility study	1.46	4.61	5.28	NA	NA	0.05	000
91012	TC	A	Esophagus motility study	0.00	3.97	4.61	NA	NA	0.01	000
91012	26	A	Esophagus motility study	1.46	0.64	0.67	0.64	0.67	0.04	000
91020		A	Gastric motility studies	1.44	4.29	4.64	NA	NA	0.05	000
91020	TC	A	Gastric motility studies	0.00	3.67	4.02	NA	NA	0.01	000
91020	26	A	Gastric motility studies	1.44	0.62	0.62	0.62	0.62	0.04	000
91022		A	Duodenal motility study	1.44	2.83	3.43	NA	NA	0.05	000
91022	TC	A	Duodenal motility study	0.00	2.19	2.76	NA	NA	0.01	000
91022	26	A	Duodenal motility study	1.44	0.64	0.67	0.64	0.67	0.04	000
91030		A	Acid perfusion of esophagus	0.91	2.47	2.73	NA	NA	0.03	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.07	2.31	NA	NA	0.01	000
91030	26	A	Acid perfusion of esophagus	0.91	0.40	0.42	0.40	0.42	0.02	000
91034		A	Gastroesophageal reflux test	0.97	3.64	4.20	NA	NA	0.03	000
91034	TC	A	Gastroesophageal reflux test	0.00	3.22	3.78	NA	NA	0.01	000
91034	26	A	Gastroesophageal reflux test	0.97	0.42	0.42	0.42	0.42	0.02	000
91035		A	G-esoph reflx tst w/electrod	1.59	9.90	10.85	NA	NA	0.06	000
91035	TC	A	G-esoph reflx tst w/electrod	0.00	9.22	10.15	NA	NA	0.01	000
91035	26	A	G-esoph reflx tst w/electrod	1.59	0.68	0.70	0.68	0.70	0.05	000
91037		A	Esoph imped function test	0.97	2.98	3.22	NA	NA	0.06	000
91037	TC	A	Esoph imped function test	0.00	2.56	2.79	NA	NA	0.01	000
91037	26	A	Esoph imped function test	0.97	0.42	0.43	0.42	0.43	0.05	000
91038		A	Esoph imped funct test > 1h	1.10	2.39	2.58	NA	NA	0.05	000
91038	TC	A	Esoph imped funct test > 1h	0.00	1.91	2.09	NA	NA	0.01	000
91038	26	A	Esoph imped funct test > 1h	1.10	0.48	0.49	0.48	0.49	0.04	000
91040		A	Esoph balloon distension tst	0.97	6.11	8.52	NA	NA	0.02	000
91040	TC	A	Esoph balloon distension tst	0.00	5.79	8.08	NA	NA	0.01	000
91040	26	A	Esoph balloon distension tst	0.97	0.32	0.44	0.32	0.44	0.01	000
91052		A	Gastric analysis test	0.79	2.50	2.53	NA	NA	0.02	000
91052	TC	A	Gastric analysis test	0.00	2.15	2.21	NA	NA	0.01	000
91052	26	A	Gastric analysis test	0.79	0.35	0.32	0.35	0.32	0.01	000
91055		A	Gastric intubation for smear	0.94	2.87	2.70	NA	NA	0.03	000
91055	TC	A	Gastric intubation for smear	0.00	2.41	2.36	NA	NA	0.01	000
91055	26	A	Gastric intubation for smear	0.94	0.46	0.34	0.46	0.34	0.02	000
91065		A	Breath hydrogen test	0.20	1.52	1.56	NA	NA	0.02	000
91065	TC	A	Breath hydrogen test	0.00	1.43	1.48	NA	NA	0.01	000
91065	26	A	Breath hydrogen test	0.20	0.09	0.08	0.09	0.08	0.01	000

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91105		A	Gastric intubation treatment	0.37	1.95	1.82	0.09	0.08	0.02	000
91110		A	Gi tract capsule endoscopy	3.64	17.78	20.16	NA	NA	0.11	XXX
91110	TC	A	Gi tract capsule endoscopy	0.00	16.19	18.51	NA	NA	0.01	XXX
91110	26	A	Gi tract capsule endoscopy	3.64	1.59	1.65	1.59	1.65	0.10	XXX
91111		A	Esophageal capsule endoscopy	1.00	16.03	17.74	NA	NA	0.04	XXX
91111	TC	A	Esophageal capsule endoscopy	0.00	15.59	17.27	NA	NA	0.01	XXX
91111	26	A	Esophageal capsule endoscopy	1.00	0.44	0.47	0.44	0.47	0.03	XXX
91120		A	Rectal sensation test	0.97	8.65	9.36	NA	NA	0.07	XXX
91120	TC	A	Rectal sensation test	0.00	8.27	9.02	NA	NA	0.01	XXX
91120	26	A	Rectal sensation test	0.97	0.38	0.34	0.38	0.34	0.06	XXX
91122		A	Anal pressure record	1.77	3.72	4.24	NA	NA	0.08	000
91122	TC	A	Anal pressure record	0.00	3.08	3.60	NA	NA	0.01	000
91122	26	A	Anal pressure record	1.77	0.64	0.64	0.64	0.64	0.07	000
91123		B	Irrigate fecal impaction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91132		C	Electrogastrography	0.00	0.00	0.00	NA	NA	0.00	XXX
91132	TC	C	Electrogastrography	0.00	0.00	0.00	NA	NA	0.00	XXX
91132	26	A	Electrogastrography	0.52	0.20	0.23	0.20	0.23	0.02	XXX
91133		C	Electrogastrography w/test	0.00	0.00	0.00	NA	NA	0.00	XXX
91133	TC	C	Electrogastrography w/test	0.00	0.00	0.00	NA	NA	0.00	XXX
91133	26	A	Electrogastrography w/test	0.66	0.29	0.31	0.29	0.31	0.03	XXX
91299		C	Gastroenterology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
91299	TC	C	Gastroenterology procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
91299	26	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92002		A	Eye exam, new patient	0.88	1.16	1.03	0.41	0.33	0.05	XXX
92004		A	Eye exam, new patient	1.82	2.01	1.76	0.89	0.71	0.09	XXX
92012		A	Eye exam established pat	0.92	1.25	1.10	0.50	0.38	0.05	XXX
92014		A	Eye exam & treatment	1.42	1.75	1.52	0.75	0.57	0.08	XXX
92015		N	Refraction	0.38	0.15	0.40	0.14	0.13	0.02	XXX
92018		A	New eye exam & treatment	2.50	NA	NA	1.41	1.10	0.11	XXX
92019		A	Eye exam & treatment	1.31	NA	NA	0.57	0.47	0.06	XXX
92020		A	Special eye evaluation	0.37	0.34	0.30	0.20	0.16	0.02	XXX
92025		A	Corneal topography	0.35	0.60	0.53	NA	NA	0.02	XXX
92025	TC	A	Corneal topography	0.00	0.41	0.38	NA	NA	0.01	XXX
92025	26	A	Corneal topography	0.35	0.19	0.15	0.19	0.15	0.01	XXX
92060		A	Special eye evaluation	0.69	0.97	0.83	NA	NA	0.03	XXX
92060	TC	A	Special eye evaluation	0.00	0.61	0.54	NA	NA	0.01	XXX
92060	26	A	Special eye evaluation	0.69	0.36	0.29	0.36	0.29	0.02	XXX
92065		A	Orthoptic/pleoptic training	0.37	0.98	0.85	NA	NA	0.02	XXX
92065	TC	A	Orthoptic/pleoptic training	0.00	0.85	0.73	NA	NA	0.01	XXX

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92065	26	A	Orthoptic/pleoptic training	0.37	0.13	0.12	0.13	0.12	0.01	XXX
92070		A	Fitting of contact lens	0.70	1.11	1.01	0.36	0.29	0.04	XXX
92081		A	Visual field examination(s)	0.36	1.11	1.00	NA	NA	0.03	XXX
92081	TC	A	Visual field examination(s)	0.00	0.94	0.86	NA	NA	0.01	XXX
92081	26	A	Visual field examination(s)	0.36	0.17	0.14	0.17	0.14	0.02	XXX
92082		A	Visual field examination(s)	0.44	1.51	1.38	NA	NA	0.04	XXX
92082	TC	A	Visual field examination(s)	0.00	1.30	1.20	NA	NA	0.01	XXX
92082	26	A	Visual field examination(s)	0.44	0.21	0.18	0.21	0.18	0.03	XXX
92083		A	Visual field examination(s)	0.50	1.76	1.58	NA	NA	0.03	XXX
92083	TC	A	Visual field examination(s)	0.00	1.49	1.37	NA	NA	0.01	XXX
92083	26	A	Visual field examination(s)	0.50	0.27	0.21	0.27	0.21	0.02	XXX
92100		A	Serial tonometry exam(s)	0.92	1.54	1.37	0.46	0.36	0.04	XXX
92120		A	Tonography & eye evaluation	0.81	1.19	1.07	0.39	0.32	0.04	XXX
92130		A	Water provocation tonography	0.81	1.44	1.28	0.44	0.35	0.04	XXX
92135		A	Ophth dx imaging post seg	0.35	0.93	0.85	NA	NA	0.02	XXX
92135	TC	A	Ophth dx imaging post seg	0.00	0.74	0.69	NA	NA	0.01	XXX
92135	26	A	Ophth dx imaging post seg	0.35	0.19	0.16	0.19	0.16	0.01	XXX
92136		A	Ophthalmic biometry	0.54	1.66	1.55	NA	NA	0.02	XXX
92136	TC	A	Ophthalmic biometry	0.00	1.35	1.30	NA	NA	0.01	XXX
92136	26	A	Ophthalmic biometry	0.54	0.31	0.25	0.31	0.25	0.01	XXX
92140		A	Glaucoma provocative tests	0.50	1.07	0.98	0.23	0.19	0.02	XXX
92225		A	Special eye exam, initial	0.38	0.33	0.27	0.20	0.16	0.02	XXX
92226		A	Special eye exam, subsequent	0.33	0.32	0.26	0.19	0.15	0.01	XXX
92230		A	Eye exam with photos	0.60	0.87	0.91	0.32	0.24	0.03	XXX
92235		A	Eye exam with photos	0.81	2.64	2.46	NA	NA	0.03	XXX
92235	TC	A	Eye exam with photos	0.00	2.16	2.09	NA	NA	0.01	XXX
92235	26	A	Eye exam with photos	0.81	0.48	0.37	0.48	0.37	0.02	XXX
92240		A	Icg angiography	1.10	5.02	4.94	NA	NA	0.03	XXX
92240	TC	A	Icg angiography	0.00	4.37	4.43	NA	NA	0.01	XXX
92240	26	A	Icg angiography	1.10	0.65	0.51	0.65	0.51	0.02	XXX
92250		A	Eye exam with photos	0.44	1.49	1.41	NA	NA	0.02	XXX
92250	TC	A	Eye exam with photos	0.00	1.27	1.23	NA	NA	0.01	XXX
92250	26	A	Eye exam with photos	0.44	0.22	0.18	0.22	0.18	0.01	XXX
92260		A	Ophthalmoscopy/dynamometry	0.20	0.28	0.26	0.11	0.09	0.01	XXX
92265		A	Eye muscle evaluation	0.81	1.33	1.18	NA	NA	0.02	XXX
92265	TC	A	Eye muscle evaluation	0.00	0.87	0.87	NA	NA	0.01	XXX
92265	26	A	Eye muscle evaluation	0.81	0.46	0.31	0.46	0.31	0.01	XXX
92270		A	Electro-oculography	0.81	1.48	1.44	NA	NA	0.02	XXX
92270	TC	A	Electro-oculography	0.00	1.15	1.15	NA	NA	0.01	XXX

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92270	26	A	Electro-oculography	0.81	0.33	0.29	0.33	0.29	0.01	XXX
92275		A	Electroretinography	1.01	2.89	2.49	NA	NA	0.05	XXX
92275	TC	A	Electroretinography	0.00	2.31	2.04	NA	NA	0.02	XXX
92275	26	A	Electroretinography	1.01	0.58	0.45	0.58	0.45	0.03	XXX
92283		A	Color vision examination	0.17	1.14	1.03	NA	NA	0.02	XXX
92283	TC	A	Color vision examination	0.00	1.06	0.96	NA	NA	0.01	XXX
92283	26	A	Color vision examination	0.17	0.08	0.07	0.08	0.07	0.01	XXX
92284		A	Dark adaptation eye exam	0.24	1.22	1.29	NA	NA	0.02	XXX
92284	TC	A	Dark adaptation eye exam	0.00	1.12	1.21	NA	NA	0.01	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.10	0.08	0.10	0.08	0.01	XXX
92285		A	Eye photography	0.20	0.90	0.87	NA	NA	0.03	XXX
92285	TC	A	Eye photography	0.00	0.80	0.78	NA	NA	0.01	XXX
92285	26	A	Eye photography	0.20	0.10	0.09	0.10	0.09	0.02	XXX
92286		A	Internal eye photography	0.66	2.40	2.38	NA	NA	0.02	XXX
92286	TC	A	Internal eye photography	0.00	2.05	2.10	NA	NA	0.01	XXX
92286	26	A	Internal eye photography	0.66	0.35	0.28	0.35	0.28	0.01	XXX
92287		A	Internal eye photography	0.81	2.26	2.12	0.46	0.35	0.03	XXX
92310		N	Contact lens fitting	1.17	1.27	1.26	0.43	0.42	0.06	XXX
92311		A	Contact lens fitting	1.08	1.57	1.35	0.49	0.38	0.06	XXX
92312		A	Contact lens fitting	1.26	1.82	1.52	0.55	0.45	0.04	XXX
92313		A	Contact lens fitting	0.92	1.72	1.45	0.49	0.37	0.05	XXX
92314		N	Prescription of contact lens	0.69	1.29	1.25	0.25	0.25	0.03	XXX
92315		A	Prescription of contact lens	0.45	1.46	1.27	0.19	0.15	0.03	XXX
92316		A	Prescription of contact lens	0.68	1.96	1.60	0.40	0.29	0.03	XXX
92317		A	Prescription of contact lens	0.45	2.18	1.49	0.07	0.12	0.01	XXX
92325		A	Modification of contact lens	0.00	0.93	0.79	NA	NA	0.01	XXX
92326		A	Replacement of contact lens	0.00	0.80	0.93	NA	NA	0.01	XXX
92340		N	Fitting of spectacles	0.37	0.51	0.56	0.14	0.13	0.02	XXX
92341		N	Fitting of spectacles	0.47	0.55	0.60	0.17	0.17	0.02	XXX
92342		N	Fitting of spectacles	0.53	0.57	0.62	0.19	0.19	0.03	XXX
92352		B	Special spectacles fitting	0.37	0.64	0.67	0.14	0.13	0.02	XXX
92353		B	Special spectacles fitting	0.50	0.69	0.71	0.18	0.18	0.03	XXX
92354		B	Special spectacles fitting	0.00	0.30	1.95	NA	NA	0.01	XXX
92355		B	Special spectacles fitting	0.00	0.47	1.23	NA	NA	0.01	XXX
92358		B	Eye prosthesis service	0.00	0.25	0.40	NA	NA	0.01	XXX
92370		N	Repair & adjust spectacles	0.32	0.45	0.48	0.12	0.11	0.02	XXX
92371		B	Repair & adjust spectacles	0.00	0.26	0.34	NA	NA	0.01	XXX
92499		C	Eye service or procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
92499	TC	C	Eye service or procedure	0.00	0.00	0.00	NA	NA	0.00	XXX

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92499	26	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92502		A	Ear and throat examination	1.51	NA	NA	1.13	1.03	0.06	000
92504		A	Ear microscopy examination	0.18	0.63	0.59	0.09	0.08	0.01	XXX
92506		A	Speech/hearing evaluation	0.86	3.69	3.37	0.39	0.34	0.05	XXX
92507		A	Speech/hearing therapy	0.52	1.37	1.23	0.21	0.19	0.02	XXX
92508		A	Speech/hearing therapy	0.26	0.75	0.60	0.12	0.11	0.01	XXX
92511		A	Nasopharyngoscopy	0.84	3.23	3.22	0.79	0.73	0.03	000
92512		A	Nasal function studies	0.55	1.04	1.04	0.26	0.21	0.02	XXX
92516		A	Facial nerve function test	0.43	1.28	1.24	0.20	0.18	0.02	XXX
92520		A	Laryngeal function studies	0.75	1.09	0.92	0.36	0.31	0.03	XXX
92526		A	Oral function therapy	1.34	0.65	1.39	0.51	0.27	0.02	XXX
92531		B	Spontaneous nystagmus study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92532		B	Positional nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92533		B	Caloric vestibular test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92534		B	Optokinetic nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92540		A	Basic vestibular evaluation	1.50	1.09	1.09	NA	NA	0.04	XXX
92540	TC	A	Basic vestibular evaluation	0.00	0.45	0.45	NA	NA	0.01	XXX
92540	26	A	Basic vestibular evaluation	1.50	0.64	0.64	0.64	0.64	0.03	XXX
92541		A	Spontaneous nystagmus test	0.40	0.38	0.97	NA	NA	0.02	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	0.21	0.82	NA	NA	0.01	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.17	0.15	0.17	0.15	0.01	XXX
92542		A	Positional nystagmus test	0.33	0.34	1.07	NA	NA	0.02	XXX
92542	TC	A	Positional nystagmus test	0.00	0.20	0.94	NA	NA	0.01	XXX
92542	26	A	Positional nystagmus test	0.33	0.14	0.13	0.14	0.13	0.01	XXX
92543		A	Caloric vestibular test	0.10	0.25	0.55	NA	NA	0.02	XXX
92543	TC	A	Caloric vestibular test	0.00	0.21	0.51	NA	NA	0.01	XXX
92543	26	A	Caloric vestibular test	0.10	0.04	0.04	0.04	0.04	0.01	XXX
92544		A	Optokinetic nystagmus test	0.26	0.31	0.87	NA	NA	0.02	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	0.20	0.77	NA	NA	0.01	XXX
92544	26	A	Optokinetic nystagmus test	0.26	0.11	0.10	0.11	0.10	0.01	XXX
92545		A	Oscillating tracking test	0.23	0.30	0.83	NA	NA	0.02	XXX
92545	TC	A	Oscillating tracking test	0.00	0.20	0.74	NA	NA	0.01	XXX
92545	26	A	Oscillating tracking test	0.23	0.10	0.09	0.10	0.09	0.01	XXX
92546		A	Sinusoidal rotational test	0.29	2.18	2.01	NA	NA	0.02	XXX
92546	TC	A	Sinusoidal rotational test	0.00	2.06	1.90	NA	NA	0.01	XXX
92546	26	A	Sinusoidal rotational test	0.29	0.12	0.11	0.12	0.11	0.01	XXX
92547		A	Supplemental electrical test	0.00	0.12	0.11	0.12	0.11	0.01	ZZZ
92548		A	Posturography	0.50	2.20	2.01	NA	NA	0.02	XXX
92548	TC	A	Posturography	0.00	1.99	1.82	NA	NA	0.01	XXX

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92548	26	A	Posturography	0.50	0.21	0.19	0.21	0.19	0.01	XXX
92550		A	Tympanometry & reflex thresh	0.35	0.21	0.21	NA	NA	0.01	XXX
92551		N	Pure tone hearing test, air	0.00	0.27	0.28	NA	NA	0.01	XXX
92552		A	Pure tone audiometry, air	0.00	0.66	0.59	NA	NA	0.01	XXX
92553		A	Audiometry, air & bone	0.00	0.80	0.76	NA	NA	0.01	XXX
92555		A	Speech threshold audiometry	0.00	0.47	0.42	NA	NA	0.01	XXX
92556		A	Speech audiometry, complete	0.00	0.71	0.65	NA	NA	0.01	XXX
92557		A	Comprehensive hearing test	0.60	0.38	0.50	0.28	0.42	0.02	XXX
92559		N	Group audiometric testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92560		N	Bekesy audiometry, screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92561		A	Bekesy audiometry, diagnosis	0.00	0.86	0.76	NA	NA	0.01	XXX
92562		A	Loudness balance test	0.00	0.96	0.69	NA	NA	0.01	XXX
92563		A	Tone decay hearing test	0.00	0.67	0.57	NA	NA	0.01	XXX
92564		A	Sisi hearing test	0.00	0.62	0.53	NA	NA	0.01	XXX
92565		A	Stenger test, pure tone	0.00	0.31	0.32	NA	NA	0.01	XXX
92567		A	Tympanometry	0.20	0.17	0.22	0.09	0.16	0.01	XXX
92568		A	Acoustic refl threshold tst	0.29	0.14	0.16	0.13	0.16	0.01	XXX
92570		A	Acoustic immittance testing	0.55	0.30	0.30	0.25	0.25	0.02	XXX
92571		A	Filtered speech hearing test	0.00	0.51	0.44	NA	NA	0.01	XXX
92572		A	Staggered spondaic word test	0.00	1.07	0.62	NA	NA	0.01	XXX
92575		A	Sensorineural acuity test	0.00	1.36	1.06	NA	NA	0.01	XXX
92576		A	Synthetic sentence test	0.00	0.74	0.59	NA	NA	0.01	XXX
92577		A	Stenger test, speech	0.00	0.35	0.40	NA	NA	0.01	XXX
92579		A	Visual audiometry (vra)	0.70	0.50	0.47	0.34	0.37	0.03	XXX
92582		A	Conditioning play audiometry	0.00	1.36	1.15	NA	NA	0.01	XXX
92583		A	Select picture audiometry	0.00	0.98	0.88	NA	NA	0.01	XXX
92584		A	Electrocochleography	0.00	1.51	1.64	NA	NA	0.01	XXX
92585		A	Auditor evoke potent, compre	0.50	2.47	2.22	NA	NA	0.02	XXX
92585	TC	A	Auditor evoke potent, compre	0.00	2.25	2.03	NA	NA	0.01	XXX
92585	26	A	Auditor evoke potent, compre	0.50	0.22	0.19	0.22	0.19	0.01	XXX
92586		A	Auditor evoke potent, limit	0.00	1.78	1.65	NA	NA	0.01	XXX
92587		A	Evoked auditory test	0.13	0.73	0.81	NA	NA	0.02	XXX
92587	TC	A	Evoked auditory test	0.00	0.67	0.76	NA	NA	0.01	XXX
92587	26	A	Evoked auditory test	0.13	0.06	0.05	0.06	0.05	0.01	XXX
92588		A	Evoked auditory test	0.36	1.30	1.28	NA	NA	0.02	XXX
92588	TC	A	Evoked auditory test	0.00	1.14	1.14	NA	NA	0.01	XXX
92588	26	A	Evoked auditory test	0.36	0.16	0.14	0.16	0.14	0.01	XXX
92590		N	Hearing aid exam, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92591		N	Hearing aid exam, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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92592		N	Hearing aid check, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92593		N	Hearing aid check, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92594		N	Electro hearng aid test, one	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92595		N	Electro hearng aid tst, both	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92596		A	Ear protector evaluation	0.00	1.39	1.03	NA	NA	0.01	XXX
92597		A	Oral speech device eval	1.26	0.67	1.61	0.60	0.41	0.03	XXX
92601		A	Cochlear implt f/up exam < 7	2.30	1.51	1.79	1.02	1.39	0.09	XXX
92602		A	Reprogram cochlear implt < 7	1.30	1.20	1.27	0.55	0.86	0.05	XXX
92603		A	Cochlear implt f/up exam 7 >	2.25	1.54	1.51	1.03	1.13	0.09	XXX
92604		A	Reprogram cochlear implt 7 >	1.25	0.99	0.97	0.57	0.66	0.05	XXX
92605		B	Eval for nonspeech device rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92606		B	Non-speech device service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92607		A	Ex for speech device rx, 1hr	0.00	4.69	4.33	NA	NA	0.06	XXX
92608		A	Ex for speech device rx addl	0.00	1.18	0.88	NA	NA	0.01	XXX
92609		A	Use of speech device service	0.00	2.70	2.35	NA	NA	0.03	XXX
92610		A	Evaluate swallowing function	1.30	0.79	1.79	0.57	1.73	0.01	XXX
92611		A	Motion fluoroscopy/swallow	1.34	0.97	1.98	NA	NA	0.01	XXX
92612		A	Endoscopy swallow tst (fees)	1.27	3.13	3.00	0.60	0.53	0.05	XXX
92613		A	Endoscopy swallow tst (fees)	0.71	0.33	0.31	0.33	0.31	0.03	XXX
92614		A	Laryngoscopic sensory test	1.27	2.68	2.53	0.62	0.54	0.05	XXX
92615		A	Eval laryngoscopy sense tst	0.63	0.30	0.28	0.30	0.27	0.02	XXX
92616		A	Fees w/laryngeal sense test	1.88	3.36	3.29	0.86	0.77	0.08	XXX
92617		A	Interprt fees/laryngeal test	0.79	0.36	0.33	0.36	0.33	0.03	XXX
92620		A	Auditory function, 60 min	1.50	0.97	0.58	0.74	0.52	0.06	XXX
92621		A	Auditory function, + 15 min	0.35	0.23	0.13	0.15	0.11	0.01	ZZZ
92625		A	Tinnitus assessment	1.15	0.69	0.47	0.52	0.43	0.04	XXX
92626		A	Eval aud rehab status	1.40	0.91	0.79	0.62	0.71	0.05	XXX
92627		A	Eval aud status rehab add-on	0.33	0.23	0.20	0.15	0.18	0.01	ZZZ
92630		I	Aud rehab pre-ling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92633		I	Aud rehab postling hear loss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92640		A	Aud brainstem implt programg	1.76	0.97	0.44	0.65	0.36	0.27	XXX
92700		C	Ent procedure/service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92950		A	Heart/lung resuscitation cpr	3.79	3.49	3.49	0.88	0.86	0.21	000
92953		A	Temporary external pacing	0.23	NA	NA	0.06	0.08	0.01	000
92960		A	Cardioversion electric, ext	2.25	3.13	4.42	0.97	1.30	0.11	000
92961		A	Cardioversion, electric, int	4.59	NA	NA	1.75	2.27	0.33	000
92970		A	Cardioassist, internal	3.51	NA	NA	1.11	1.33	0.17	000
92971		A	Cardioassist, external	1.77	NA	NA	0.70	0.97	0.09	000
92973		A	Percut coronary thrombectomy	3.28	NA	NA	1.09	1.54	0.16	ZZZ

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92974		A	Cath place, cardio brachytx	3.00	NA	NA	1.00	1.41	0.17	ZZZ
92975		A	Dissolve clot, heart vessel	7.24	NA	NA	2.45	3.36	0.36	000
92977		A	Dissolve clot, heart vessel	0.00	1.24	2.80	NA	NA	0.02	XXX
92978		C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92978	TC	C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92978	26	A	Intravasc us, heart add-on	1.80	0.60	0.84	0.60	0.84	0.09	ZZZ
92979		C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92979	TC	C	Intravasc us, heart add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
92979	26	A	Intravasc us, heart add-on	1.44	0.48	0.68	0.48	0.68	0.07	ZZZ
92980		A	Insert intracoronary stent	14.82	NA	NA	5.10	7.14	0.73	000
92981		A	Insert intracoronary stent	4.16	NA	NA	1.39	1.95	0.20	ZZZ
92982		A	Coronary artery dilation	10.96	NA	NA	3.81	5.32	0.54	000
92984		A	Coronary artery dilation	2.97	NA	NA	0.99	1.39	0.15	ZZZ
92986		A	Revision of aortic valve	22.85	NA	NA	10.02	13.50	1.17	090
92987		A	Revision of mitral valve	23.63	NA	NA	10.29	13.95	1.13	090
92990		A	Revision of pulmonary valve	18.27	NA	NA	8.35	10.82	0.88	090
92992		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92993		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92995		A	Coronary atherectomy	12.07	NA	NA	4.18	5.87	0.59	000
92996		A	Coronary atherectomy add-on	3.26	NA	NA	1.08	1.53	0.16	ZZZ
92997		A	Pul art balloon repr, percut	11.98	NA	NA	4.13	5.05	0.58	000
92998		A	Pul art balloon repr, percut	5.99	NA	NA	1.99	2.63	0.29	ZZZ
93000		A	Electrocardiogram, complete	0.17	0.28	0.36	NA	NA	0.02	XXX
93005		A	Electrocardiogram, tracing	0.00	0.22	0.29	NA	NA	0.01	XXX
93010		A	Electrocardiogram report	0.17	0.06	0.07	0.06	0.07	0.01	XXX
93012		A	Transmission of ecg	0.00	3.53	4.61	NA	NA	0.02	XXX
93014		A	Report on transmitted ecg	0.52	0.18	0.22	0.18	0.22	0.02	XXX
93015		A	Cardiovascular stress test	0.75	1.36	1.79	NA	NA	0.03	XXX
93016		A	Cardiovascular stress test	0.45	0.15	0.20	0.15	0.20	0.01	XXX
93017		A	Cardiovascular stress test	0.00	1.11	1.46	NA	NA	0.01	XXX
93018		A	Cardiovascular stress test	0.30	0.10	0.13	0.10	0.13	0.01	XXX
93024		A	Cardiac drug stress test	1.17	1.68	2.02	NA	NA	0.04	XXX
93024	TC	A	Cardiac drug stress test	0.00	1.28	1.51	NA	NA	0.01	XXX
93024	26	A	Cardiac drug stress test	1.17	0.40	0.51	0.40	0.51	0.03	XXX
93025		A	Microvolt t-wave assess	0.75	3.16	4.63	NA	NA	0.03	XXX
93025	TC	A	Microvolt t-wave assess	0.00	2.91	4.29	NA	NA	0.01	XXX
93025	26	A	Microvolt t-wave assess	0.75	0.25	0.34	0.25	0.34	0.02	XXX
93040		A	Rhythm ECG with report	0.16	0.16	0.19	NA	NA	0.02	XXX
93041		A	Rhythm ECG, tracing	0.00	0.12	0.14	NA	NA	0.01	XXX

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93042		A	Rhythm ECG, report	0.16	0.04	0.05	0.04	0.05	0.01	XXX
93224		A	ECG monitor/report, 24 hrs	0.52	1.70	2.37	NA	NA	0.03	XXX
93225		A	ECG monitor/record, 24 hrs	0.00	0.62	0.85	NA	NA	0.01	XXX
93226		A	ECG monitor/report, 24 hrs	0.00	0.88	1.28	NA	NA	0.01	XXX
93227		A	ECG monitor/review, 24 hrs	0.52	0.20	0.24	0.20	0.24	0.01	XXX
93228		A	Remote 30 day ecg rev/report	0.52	0.19	0.18	0.19	0.18	0.03	XXX
93229		C	Remote 30 day ecg tech supp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93230		A	ECG monitor/report, 24 hrs	0.52	1.74	2.42	NA	NA	0.03	XXX
93231		A	Ecg monitor/record, 24 hrs	0.00	0.54	0.81	NA	NA	0.01	XXX
93232		A	ECG monitor/report, 24 hrs	0.00	1.02	1.40	NA	NA	0.01	XXX
93233		A	ECG monitor/review, 24 hrs	0.52	0.18	0.21	0.18	0.21	0.01	XXX
93235		C	ECG monitor/report, 24 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93236		C	ECG monitor/report, 24 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93237		A	ECG monitor/review, 24 hrs	0.45	0.15	0.20	0.15	0.20	0.02	XXX
93268		A	ECG record/review	0.52	4.88	6.24	NA	NA	0.04	XXX
93270		A	ECG recording	0.00	0.21	0.45	NA	NA	0.01	XXX
93271		A	Ecg/monitoring and analysis	0.00	4.50	5.58	NA	NA	0.02	XXX
93272		A	Ecg/review, interpret only	0.52	0.17	0.21	0.17	0.21	0.01	XXX
93278		A	ECG/signal-averaged	0.25	0.51	0.71	NA	NA	0.02	XXX
93278	TC	A	ECG/signal-averaged	0.00	0.42	0.61	NA	NA	0.01	XXX
93278	26	A	ECG/signal-averaged	0.25	0.09	0.10	0.09	0.10	0.01	XXX
93279		A	Pm device progr eval, sngl	0.65	0.61	0.80	NA	NA	0.03	XXX
93279	TC	A	Pm device progr eval, sngl	0.00	0.39	0.49	NA	NA	0.01	XXX
93279	26	A	Pm device progr eval, sngl	0.65	0.22	0.31	0.22	0.31	0.02	XXX
93280		A	Pm device progr eval, dual	0.77	0.70	0.95	NA	NA	0.03	XXX
93280	TC	A	Pm device progr eval, dual	0.00	0.44	0.57	NA	NA	0.01	XXX
93280	26	A	Pm device progr eval, dual	0.77	0.26	0.38	0.26	0.38	0.02	XXX
93281		A	Pm device progr eval, multi	0.90	0.81	1.10	NA	NA	0.03	XXX
93281	TC	A	Pm device progr eval, multi	0.00	0.51	0.66	NA	NA	0.01	XXX
93281	26	A	Pm device progr eval, multi	0.90	0.30	0.44	0.30	0.44	0.02	XXX
93282		A	Icd device prog eval, 1 sngl	0.85	0.74	0.99	NA	NA	0.03	XXX
93282	TC	A	Icd device prog eval, 1 sngl	0.00	0.45	0.59	NA	NA	0.01	XXX
93282	26	A	Icd device prog eval, 1 sngl	0.85	0.29	0.40	0.29	0.40	0.02	XXX
93283		A	Icd device progr eval, dual	1.15	0.91	1.21	NA	NA	0.04	XXX
93283	TC	A	Icd device progr eval, dual	0.00	0.52	0.68	NA	NA	0.01	XXX
93283	26	A	Icd device progr eval, dual	1.15	0.39	0.53	0.39	0.53	0.03	XXX
93284		A	Icd device progr eval, mult	1.25	1.01	1.40	NA	NA	0.04	XXX
93284	TC	A	Icd device progr eval, mult	0.00	0.59	0.78	NA	NA	0.01	XXX
93284	26	A	Icd device progr eval, mult	1.25	0.42	0.62	0.42	0.62	0.03	XXX

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93285		A	Ilr device eval progr	0.52	0.53	0.71	NA	NA	0.02	XXX
93285	TC	A	Ilr device eval progr	0.00	0.35	0.45	NA	NA	0.01	XXX
93285	26	A	Ilr device eval progr	0.52	0.18	0.26	0.18	0.26	0.01	XXX
93286		A	Pre-op pm device eval	0.30	0.42	0.42	NA	NA	0.02	XXX
93286	TC	A	Pre-op pm device eval	0.00	0.31	0.32	NA	NA	0.01	XXX
93286	26	A	Pre-op pm device eval	0.30	0.11	0.10	0.11	0.10	0.01	XXX
93287		A	Pre-op icd device eval	0.45	0.50	0.51	NA	NA	0.02	XXX
93287	TC	A	Pre-op icd device eval	0.00	0.34	0.35	NA	NA	0.01	XXX
93287	26	A	Pre-op icd device eval	0.45	0.16	0.16	0.16	0.16	0.01	XXX
93288		A	Pm device eval in person	0.43	0.49	0.67	NA	NA	0.02	XXX
93288	TC	A	Pm device eval in person	0.00	0.35	0.46	NA	NA	0.01	XXX
93288	26	A	Pm device eval in person	0.43	0.14	0.21	0.14	0.21	0.01	XXX
93289		A	Icd device interrogate	0.92	0.74	0.96	NA	NA	0.03	XXX
93289	TC	A	Icd device interrogate	0.00	0.43	0.57	NA	NA	0.01	XXX
93289	26	A	Icd device interrogate	0.92	0.31	0.39	0.31	0.39	0.02	XXX
93290		A	Icm device eval	0.43	0.41	0.41	NA	NA	0.02	XXX
93290	TC	A	Icm device eval	0.00	0.25	0.26	NA	NA	0.01	XXX
93290	26	A	Icm device eval	0.43	0.16	0.15	0.16	0.15	0.01	XXX
93291		A	Ilr device interrogate	0.43	0.47	0.63	NA	NA	0.02	XXX
93291	TC	A	Ilr device interrogate	0.00	0.32	0.42	NA	NA	0.01	XXX
93291	26	A	Ilr device interrogate	0.43	0.15	0.21	0.15	0.21	0.01	XXX
93292		A	Wcd device interrogate	0.43	0.38	0.52	NA	NA	0.02	XXX
93292	TC	A	Wcd device interrogate	0.00	0.24	0.31	NA	NA	0.01	XXX
93292	26	A	Wcd device interrogate	0.43	0.14	0.21	0.14	0.21	0.01	XXX
93293		A	Pm phone r-strip device eval	0.32	0.99	1.18	NA	NA	0.02	XXX
93293	TC	A	Pm phone r-strip device eval	0.00	0.89	1.05	NA	NA	0.01	XXX
93293	26	A	Pm phone r-strip device eval	0.32	0.10	0.13	0.10	0.13	0.01	XXX
93294		A	Pm device interrogate remote	0.65	0.22	0.31	0.22	0.31	0.03	XXX
93295		A	Icd device interrogat remote	1.29	0.43	0.59	0.43	0.59	0.06	XXX
93296		A	Pm/icd remote tech serv	0.00	0.71	0.94	NA	NA	0.01	XXX
93297		A	Icm device interrogat remote	0.52	0.19	0.18	0.19	0.18	0.03	XXX
93298		A	Ilr device interrogat remote	0.52	0.18	0.26	0.18	0.26	0.03	XXX
93299		C	Icm/ilr remote tech serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93303		A	Echo transthoracic	1.30	3.56	4.32	NA	NA	0.04	XXX
93303	TC	A	Echo transthoracic	0.00	3.12	3.77	NA	NA	0.01	XXX
93303	26	A	Echo transthoracic	1.30	0.44	0.55	0.44	0.55	0.03	XXX
93304		A	Echo transthoracic	0.75	2.48	2.79	NA	NA	0.03	XXX
93304	TC	A	Echo transthoracic	0.00	2.23	2.49	NA	NA	0.01	XXX
93304	26	A	Echo transthoracic	0.75	0.25	0.30	0.25	0.30	0.02	XXX

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93306		A	Tte w/doppler, complete	1.30	3.47	5.27	NA	NA	0.04	XXX
93306	TC	A	Tte w/doppler, complete	0.00	3.03	4.66	NA	NA	0.01	XXX
93306	26	A	Tte w/doppler, complete	1.30	0.44	0.61	0.44	0.61	0.03	XXX
93307		A	Tte w/o doppler, complete	0.92	1.87	3.32	NA	NA	0.03	XXX
93307	TC	A	Tte w/o doppler, complete	0.00	1.56	2.91	NA	NA	0.01	XXX
93307	26	A	Tte w/o doppler, complete	0.92	0.31	0.41	0.31	0.41	0.02	XXX
93308		A	Tte, f-up or lmtd	0.53	1.87	2.32	NA	NA	0.02	XXX
93308	TC	A	Tte, f-up or lmtd	0.00	1.69	2.08	NA	NA	0.01	XXX
93308	26	A	Tte, f-up or lmtd	0.53	0.18	0.24	0.18	0.24	0.01	XXX
93312		A	Echo transesophageal	2.20	5.61	6.35	NA	NA	0.07	XXX
93312	TC	A	Echo transesophageal	0.00	4.95	5.47	NA	NA	0.02	XXX
93312	26	A	Echo transesophageal	2.20	0.66	0.88	0.66	0.88	0.05	XXX
93313		A	Echo transesophageal	0.95	NA	NA	0.17	0.15	0.05	XXX
93314		A	Echo transesophageal	1.25	5.70	6.17	NA	NA	0.05	XXX
93314	TC	A	Echo transesophageal	0.00	5.30	5.66	NA	NA	0.02	XXX
93314	26	A	Echo transesophageal	1.25	0.40	0.51	0.40	0.51	0.03	XXX
93315		C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93315	TC	C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93315	26	A	Echo transesophageal	2.78	0.89	1.18	0.89	1.18	0.16	XXX
93316		A	Echo transesophageal	0.95	NA	NA	0.22	0.25	0.05	XXX
93317		C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93317	TC	C	Echo transesophageal	0.00	0.00	0.00	NA	NA	0.00	XXX
93317	26	A	Echo transesophageal	1.83	0.54	0.63	0.54	0.63	0.16	XXX
93318		C	Echo transesophageal intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
93318	TC	C	Echo transesophageal intraop	0.00	0.00	0.00	NA	NA	0.00	XXX
93318	26	A	Echo transesophageal intraop	2.20	0.67	0.77	0.67	0.77	0.22	XXX
93320		A	Doppler echo exam, heart	0.38	0.76	1.46	NA	NA	0.02	ZZZ
93320	TC	A	Doppler echo exam, heart	0.00	0.63	1.29	NA	NA	0.01	ZZZ
93320	26	A	Doppler echo exam, heart	0.38	0.13	0.17	0.13	0.17	0.01	ZZZ
93321		A	Doppler echo exam, heart	0.15	0.44	0.67	NA	NA	0.02	ZZZ
93321	TC	A	Doppler echo exam, heart	0.00	0.39	0.60	NA	NA	0.01	ZZZ
93321	26	A	Doppler echo exam, heart	0.15	0.05	0.07	0.05	0.07	0.01	ZZZ
93325		A	Doppler color flow add-on	0.07	0.41	1.03	NA	NA	0.02	ZZZ
93325	TC	A	Doppler color flow add-on	0.00	0.39	1.00	NA	NA	0.01	ZZZ
93325	26	A	Doppler color flow add-on	0.07	0.02	0.03	0.02	0.03	0.01	ZZZ
93350		A	Stress tte only	1.46	3.61	4.14	NA	NA	0.04	XXX
93350	TC	A	Stress tte only	0.00	3.12	3.47	NA	NA	0.01	XXX
93350	26	A	Stress tte only	1.46	0.49	0.67	0.49	0.67	0.03	XXX
93351		A	Stress tte complete	1.75	4.11	4.91	NA	NA	0.06	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
93351	TC	A	Stress tte complete	0.00	3.52	4.06	NA	NA	0.02	XXX
93351	26	A	Stress tte complete	1.75	0.59	0.85	0.59	0.85	0.04	XXX
93352		A	Admin ecg contrast agent	0.19	0.62	0.80	NA	NA	0.01	ZZZ
93501		A	Right heart catheterization	3.02	13.55	17.17	NA	NA	0.09	000
93501	TC	A	Right heart catheterization	0.00	12.54	15.79	NA	NA	0.02	000
93501	26	A	Right heart catheterization	3.02	1.01	1.38	1.01	1.38	0.07	000
93503		A	Insert/place heart catheter	2.91	NA	NA	0.77	0.77	0.18	000
93505		A	Biopsy of heart lining	4.37	15.07	15.93	NA	NA	0.21	000
93505	TC	A	Biopsy of heart lining	0.00	13.61	13.93	NA	NA	0.02	000
93505	26	A	Biopsy of heart lining	4.37	1.46	2.00	1.46	2.00	0.19	000
93508		A	Cath placement, angiography	4.09	20.72	23.86	NA	NA	0.12	000
93508	TC	A	Cath placement, angiography	0.00	19.36	21.86	NA	NA	0.03	000
93508	26	A	Cath placement, angiography	4.09	1.36	2.00	1.36	2.00	0.09	000
93510		A	Left heart catheterization	4.32	20.22	28.05	NA	NA	0.13	000
93510	TC	A	Left heart catheterization	0.00	18.78	25.95	NA	NA	0.03	000
93510	26	A	Left heart catheterization	4.32	1.44	2.10	1.44	2.10	0.10	000
93511		C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93511	TC	C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93511	26	A	Left heart catheterization	5.02	1.67	2.43	1.67	2.43	0.25	000
93514		C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93514	TC	C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93514	26	A	Left heart catheterization	7.04	2.35	3.25	2.35	3.25	0.34	000
93524		C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93524	TC	C	Left heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93524	26	A	Left heart catheterization	6.94	2.32	3.34	2.32	3.34	0.33	000
93526		A	Rt & Lt heart catheters	5.98	25.17	35.39	NA	NA	0.17	000
93526	TC	A	Rt & Lt heart catheters	0.00	23.18	32.51	NA	NA	0.03	000
93526	26	A	Rt & Lt heart catheters	5.98	1.99	2.88	1.99	2.88	0.14	000
93527		C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93527	TC	C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93527	26	A	Rt & Lt heart catheters	7.27	2.42	3.47	2.42	3.47	0.36	000
93528		C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93528	TC	C	Rt & Lt heart catheters	0.00	NA	NA	NA	NA	0.00	000
93528	26	A	Rt & Lt heart catheters	8.99	3.08	3.89	3.08	3.89	0.44	000
93529		C	Rt, lt heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93529	TC	C	Rt, lt heart catheterization	0.00	NA	NA	NA	NA	0.00	000
93529	26	A	Rt, lt heart catheterization	4.79	1.63	2.33	1.63	2.33	0.23	000
93530		C	Rt heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93530	TC	C	Rt heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
93530	26	A	Rt heart cath, congenital	4.22	1.41	1.88	1.41	1.88	0.24	000
93531		C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93531	TC	C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93531	26	A	R & l heart cath, congenital	8.34	2.78	3.61	2.78	3.61	0.40	000
93532		C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93532	TC	C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93532	26	A	R & l heart cath, congenital	9.99	3.33	4.21	3.33	4.21	0.48	000
93533		C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93533	TC	C	R & l heart cath, congenital	0.00	NA	NA	NA	NA	0.00	000
93533	26	A	R & l heart cath, congenital	6.69	2.22	2.85	2.22	2.85	0.32	000
93539		A	Injection, cardiac cath	0.40	1.77	1.83	0.13	0.19	0.02	000
93540		A	Injection, cardiac cath	0.43	6.24	6.30	0.14	0.20	0.02	000
93541		A	Injection for lung angiogram	0.29	0.10	0.13	0.10	0.13	0.01	000
93542		A	Injection for heart x-rays	0.29	3.80	3.80	0.10	0.13	0.01	000
93543		A	Injection for heart x-rays	0.29	1.89	1.93	0.10	0.13	0.01	000
93544		A	Injection for aortography	0.25	1.33	1.36	0.08	0.12	0.01	000
93545		A	Inject for coronary x-rays	0.40	4.25	4.30	0.13	0.19	0.02	000
93555		A	Imaging, cardiac cath	0.81	0.38	1.69	NA	NA	0.03	XXX
93555	TC	A	Imaging, cardiac cath	0.00	0.11	1.32	NA	NA	0.01	XXX
93555	26	A	Imaging, cardiac cath	0.81	0.27	0.37	0.27	0.37	0.02	XXX
93556		A	Imaging, cardiac cath	0.83	0.57	2.58	NA	NA	0.03	XXX
93556	TC	A	Imaging, cardiac cath	0.00	0.29	2.20	NA	NA	0.01	XXX
93556	26	A	Imaging, cardiac cath	0.83	0.28	0.38	0.28	0.38	0.02	XXX
93561		C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93561	TC	C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93561	26	A	Cardiac output measurement	0.50	0.16	0.15	0.16	0.15	0.03	000
93562		C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93562	TC	C	Cardiac output measurement	0.00	NA	NA	NA	NA	0.00	000
93562	26	A	Cardiac output measurement	0.16	0.04	0.04	0.04	0.04	0.01	000
93571		C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93571	TC	C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93571	26	A	Heart flow reserve measure	1.80	0.60	0.83	0.60	0.83	0.09	ZZZ
93572		C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93572	TC	C	Heart flow reserve measure	0.00	NA	NA	NA	NA	0.00	ZZZ
93572	26	A	Heart flow reserve measure	1.44	0.48	0.64	0.48	0.64	0.09	ZZZ
93580		A	Transcath closure of asd	17.97	NA	NA	6.30	8.49	0.89	000
93581		A	Transcath closure of vsd	24.39	NA	NA	8.40	10.44	1.18	000
93600		C	Bundle of His recording	0.00	0.00	0.00	NA	NA	0.00	000
93600	TC	C	Bundle of His recording	0.00	0.00	0.00	NA	NA	0.00	000

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3,4]	Fully Implemented Non-Facility PE RVUs[2,4]	Year 2010 Transitional Non-Facility PE RVUs[2,4]	Fully Implemented Facility PE RVUs[2,4]	Year 2010 Transitional Facility PE RVUs[2,4]	Mal-Practice RVUs[2,4]	CPT[1]/ HCPCS
93600	26	A	Bundle of His recording	2.12	0.71	0.97	0.71	0.97	0.11	000
93602		C	Intra-atrial recording	0.00	0.00	0.00	NA	NA	0.00	000
93602	TC	C	Intra-atrial recording	0.00	0.00	0.00	NA	NA	0.00	000
93602	26	A	Intra-atrial recording	2.12	0.70	0.95	0.70	0.95	0.13	000
93603		C	Right ventricular recording	0.00	0.00	0.00	NA	NA	0.00	000
93603	TC	C	Right ventricular recording	0.00	0.00	0.00	NA	NA	0.00	000
93603	26	A	Right ventricular recording	2.12	0.70	0.95	0.70	0.95	0.14	000
93609		C	Map tachycardia, add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93609	TC	C	Map tachycardia, add-on	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93609	26	A	Map tachycardia, add-on	4.99	1.67	2.30	1.67	2.30	0.25	ZZZ
93610		C	Intra-atrial pacing	0.00	0.00	0.00	NA	NA	0.00	000
93610	TC	C	Intra-atrial pacing	0.00	0.00	0.00	NA	NA	0.00	000
93610	26	A	Intra-atrial pacing	3.02	0.99	1.34	0.99	1.34	0.19	000
93612		C	Intraventricular pacing	0.00	0.00	0.00	NA	NA	0.00	000
93612	TC	C	Intraventricular pacing	0.00	0.00	0.00	NA	NA	0.00	000
93612	26	A	Intraventricular pacing	3.02	0.99	1.32	0.99	1.32	0.20	000
93613		A	Electrophys map 3d, add-on	6.99	NA	NA	2.33	3.25	0.35	ZZZ
93615		C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93615	TC	C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93615	26	A	Esophageal recording	0.99	0.33	0.44	0.33	0.44	0.05	000
93616		C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93616	TC	C	Esophageal recording	0.00	0.00	0.00	NA	NA	0.00	000
93616	26	A	Esophageal recording	1.49	0.24	0.33	0.24	0.33	0.09	000
93618		C	Heart rhythm pacing	0.00	0.00	0.00	NA	NA	0.00	000
93618	TC	C	Heart rhythm pacing	0.00	0.00	0.00	NA	NA	0.00	000
93618	26	A	Heart rhythm pacing	4.25	1.41	2.00	1.41	2.00	0.21	000
93619		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93619	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93619	26	A	Electrophysiology evaluation	7.31	2.43	3.48	2.43	3.48	0.36	000
93620		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93620	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93620	26	A	Electrophysiology evaluation	11.57	3.87	5.41	3.87	5.41	0.58	000
93621		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93621	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93621	26	A	Electrophysiology evaluation	2.10	0.70	0.97	0.70	0.97	0.11	ZZZ
93622		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93622	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93622	26	A	Electrophysiology evaluation	3.10	1.03	1.40	1.03	1.40	0.16	ZZZ
93623		C	Stimulation, pacing heart	0.00	0.00	0.00	NA	NA	0.00	ZZZ

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93623	TC	C	Stimulation, pacing heart	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93623	26	A	Stimulation, pacing heart	2.85	0.95	1.32	0.95	1.32	0.15	ZZZ
93624		C	Electrophysiologic study	0.00	0.00	0.00	NA	NA	0.00	000
93624	TC	C	Electrophysiologic study	0.00	0.00	0.00	NA	NA	0.00	000
93624	26	A	Electrophysiologic study	4.80	1.59	2.29	1.59	2.29	0.24	000
93631		C	Heart pacing, mapping	0.00	0.00	0.00	NA	NA	0.00	000
93631	TC	C	Heart pacing, mapping	0.00	0.00	0.00	NA	NA	0.00	000
93631	26	A	Heart pacing, mapping	7.59	2.38	2.71	2.38	2.71	1.13	000
93640		C	Evaluation heart device	0.00	0.00	0.00	NA	NA	0.00	000
93640	TC	C	Evaluation heart device	0.00	0.00	0.00	NA	NA	0.00	000
93640	26	A	Evaluation heart device	3.51	1.18	1.61	1.18	1.61	0.21	000
93641		C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93641	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	NA	NA	0.00	000
93641	26	A	Electrophysiology evaluation	5.92	1.97	2.74	1.97	2.74	0.31	000
93642		A	Electrophysiology evaluation	4.88	4.91	7.09	NA	NA	0.14	000
93642	TC	A	Electrophysiology evaluation	0.00	3.27	4.76	NA	NA	0.03	000
93642	26	A	Electrophysiology evaluation	4.88	1.64	2.33	1.64	2.33	0.11	000
93650		A	Ablate heart dysrhythm focus	10.49	NA	NA	3.73	5.12	0.53	000
93651		A	Ablate heart dysrhythm focus	16.23	NA	NA	5.42	7.50	0.81	000
93652		A	Ablate heart dysrhythm focus	17.65	NA	NA	5.91	8.18	0.89	000
93660		A	Tilt table evaluation	1.89	2.03	2.63	NA	NA	0.07	000
93660	TC	A	Tilt table evaluation	0.00	1.39	1.76	NA	NA	0.02	000
93660	26	A	Tilt table evaluation	1.89	0.64	0.87	0.64	0.87	0.05	000
93662		C	Intracardiac ecg (ice)	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93662	TC	C	Intracardiac ecg (ice)	0.00	0.00	0.00	NA	NA	0.00	ZZZ
93662	26	A	Intracardiac ecg (ice)	2.80	0.93	1.29	0.93	1.29	0.14	ZZZ
93668		N	Peripheral vascular rehab	0.00	0.44	0.46	NA	NA	0.01	XXX
93701		A	Bioimpedance, cv analysis	0.00	0.55	0.71	NA	NA	0.02	XXX
93720		A	Total body plethysmography	0.17	1.00	1.05	NA	NA	0.02	XXX
93721		A	Plethysmography tracing	0.00	0.95	1.00	NA	NA	0.01	XXX
93722		A	Plethysmography report	0.17	0.05	0.05	0.05	0.05	0.01	XXX
93724		A	Analyze pacemaker system	4.88	2.28	3.64	NA	NA	0.12	000
93724	TC	A	Analyze pacemaker system	0.00	0.62	1.40	NA	NA	0.01	000
93724	26	A	Analyze pacemaker system	4.88	1.66	2.24	1.66	2.24	0.11	000
93740		B	Temperature gradient studies	0.16	NA	NA	NA	NA	0.02	XXX
93740	TC	B	Temperature gradient studies	0.00	NA	NA	NA	NA	0.01	XXX
93740	26	B	Temperature gradient studies	0.16	0.06	0.05	0.06	0.05	0.01	XXX
93745		C	Set-up cardiovert-defibrill	0.00	0.00	0.00	NA	NA	0.00	XXX
93745	TC	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	NA	NA	0.00	XXX

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93745	26	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93750		A	Interrogation vad, in person	0.92	0.48	0.48	0.30	0.30	0.05	XXX
93770		B	Measure venous pressure	0.16	NA	NA	NA	NA	0.02	XXX
93770	TC	B	Measure venous pressure	0.00	NA	NA	NA	NA	0.01	XXX
93770	26	B	Measure venous pressure	0.16	0.06	0.05	0.06	0.05	0.01	XXX
93784		A	Ambulatory BP monitoring	0.38	1.25	1.38	NA	NA	0.03	XXX
93786		A	Ambulatory BP recording	0.00	0.71	0.80	NA	NA	0.01	XXX
93788		A	Ambulatory BP analysis	0.00	0.40	0.44	NA	NA	0.01	XXX
93790		A	Review/report BP recording	0.38	0.14	0.14	0.14	0.14	0.01	XXX
93797		A	Cardiac rehab	0.18	0.26	0.30	0.07	0.08	0.01	000
93798		A	Cardiac rehab/monitor	0.28	0.34	0.42	0.10	0.12	0.01	000
93799		C	Cardiovascular procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
93799	TC	C	Cardiovascular procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
93799	26	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93875		A	Extracranial study	0.22	2.37	2.48	NA	NA	0.02	XXX
93875	TC	A	Extracranial study	0.00	2.29	2.40	NA	NA	0.01	XXX
93875	26	A	Extracranial study	0.22	0.08	0.08	0.08	0.08	0.01	XXX
93880		A	Extracranial study	0.60	5.38	5.87	NA	NA	0.05	XXX
93880	TC	A	Extracranial study	0.00	5.19	5.65	NA	NA	0.02	XXX
93880	26	A	Extracranial study	0.60	0.19	0.22	0.19	0.22	0.03	XXX
93882		A	Extracranial study	0.40	3.97	3.96	NA	NA	0.05	XXX
93882	TC	A	Extracranial study	0.00	3.84	3.83	NA	NA	0.01	XXX
93882	26	A	Extracranial study	0.40	0.13	0.13	0.13	0.13	0.04	XXX
93886		A	Intracranial study	0.94	7.85	7.23	NA	NA	0.05	XXX
93886	TC	A	Intracranial study	0.00	7.51	6.91	NA	NA	0.02	XXX
93886	26	A	Intracranial study	0.94	0.34	0.32	0.34	0.32	0.03	XXX
93888		A	Intracranial study	0.62	4.87	4.81	NA	NA	0.04	XXX
93888	TC	A	Intracranial study	0.00	4.65	4.59	NA	NA	0.01	XXX
93888	26	A	Intracranial study	0.62	0.22	0.22	0.22	0.22	0.03	XXX
93890		A	Tcd, vasoreactivity study	1.00	6.74	6.15	NA	NA	0.05	XXX
93890	TC	A	Tcd, vasoreactivity study	0.00	6.37	5.80	NA	NA	0.02	XXX
93890	26	A	Tcd, vasoreactivity study	1.00	0.37	0.35	0.37	0.35	0.03	XXX
93892		A	Tcd, emboli detect w/o inj	1.15	8.74	7.06	NA	NA	0.05	XXX
93892	TC	A	Tcd, emboli detect w/o inj	0.00	8.31	6.67	NA	NA	0.02	XXX
93892	26	A	Tcd, emboli detect w/o inj	1.15	0.43	0.39	0.43	0.39	0.03	XXX
93893		A	Tcd, emboli detect w/inj	1.15	8.06	6.88	NA	NA	0.06	XXX
93893	TC	A	Tcd, emboli detect w/inj	0.00	7.63	6.48	NA	NA	0.02	XXX
93893	26	A	Tcd, emboli detect w/inj	1.15	0.43	0.40	0.43	0.40	0.04	XXX
93922		A	Extremity study	0.25	2.85	2.96	NA	NA	0.02	XXX

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93922	TC	A	Extremity study	0.00	2.77	2.88	NA	NA	0.01	XXX
93922	26	A	Extremity study	0.25	0.08	0.08	0.08	0.08	0.01	XXX
93923		A	Extremity study	0.45	4.27	4.48	NA	NA	0.04	XXX
93923	TC	A	Extremity study	0.00	4.13	4.33	NA	NA	0.01	XXX
93923	26	A	Extremity study	0.45	0.14	0.15	0.14	0.15	0.03	XXX
93924		A	Extremity study	0.50	5.24	5.57	NA	NA	0.05	XXX
93924	TC	A	Extremity study	0.00	5.08	5.39	NA	NA	0.02	XXX
93924	26	A	Extremity study	0.50	0.16	0.18	0.16	0.18	0.03	XXX
93925		A	Lower extremity study	0.58	7.03	7.57	NA	NA	0.05	XXX
93925	TC	A	Lower extremity study	0.00	6.84	7.37	NA	NA	0.02	XXX
93925	26	A	Lower extremity study	0.58	0.19	0.20	0.19	0.20	0.03	XXX
93926		A	Lower extremity study	0.39	4.66	4.84	NA	NA	0.05	XXX
93926	TC	A	Lower extremity study	0.00	4.54	4.71	NA	NA	0.01	XXX
93926	26	A	Lower extremity study	0.39	0.12	0.13	0.12	0.13	0.04	XXX
93930		A	Upper extremity study	0.46	5.63	5.93	NA	NA	0.05	XXX
93930	TC	A	Upper extremity study	0.00	5.48	5.77	NA	NA	0.02	XXX
93930	26	A	Upper extremity study	0.46	0.15	0.16	0.15	0.16	0.03	XXX
93931		A	Upper extremity study	0.31	3.72	3.96	NA	NA	0.03	XXX
93931	TC	A	Upper extremity study	0.00	3.62	3.86	NA	NA	0.01	XXX
93931	26	A	Upper extremity study	0.31	0.10	0.10	0.10	0.10	0.02	XXX
93965		A	Extremity study	0.35	2.67	2.91	NA	NA	0.03	XXX
93965	TC	A	Extremity study	0.00	2.56	2.79	NA	NA	0.01	XXX
93965	26	A	Extremity study	0.35	0.11	0.12	0.11	0.12	0.02	XXX
93970		A	Extremity study	0.68	5.57	5.92	NA	NA	0.07	XXX
93970	TC	A	Extremity study	0.00	5.36	5.69	NA	NA	0.02	XXX
93970	26	A	Extremity study	0.68	0.21	0.23	0.21	0.23	0.05	XXX
93971		A	Extremity study	0.45	3.61	3.90	NA	NA	0.05	XXX
93971	TC	A	Extremity study	0.00	3.47	3.74	NA	NA	0.01	XXX
93971	26	A	Extremity study	0.45	0.14	0.16	0.14	0.16	0.04	XXX
93975		A	Vascular study	1.80	7.34	8.07	NA	NA	0.12	XXX
93975	TC	A	Vascular study	0.00	6.77	7.43	NA	NA	0.02	XXX
93975	26	A	Vascular study	1.80	0.57	0.64	0.57	0.64	0.10	XXX
93976		A	Vascular study	1.21	4.00	4.44	NA	NA	0.07	XXX
93976	TC	A	Vascular study	0.00	3.63	4.01	NA	NA	0.01	XXX
93976	26	A	Vascular study	1.21	0.37	0.43	0.37	0.43	0.06	XXX
93978		A	Vascular study	0.65	5.27	5.56	NA	NA	0.07	XXX
93978	TC	A	Vascular study	0.00	5.06	5.34	NA	NA	0.02	XXX
93978	26	A	Vascular study	0.65	0.21	0.22	0.21	0.22	0.05	XXX
93979		A	Vascular study	0.44	3.62	3.86	NA	NA	0.04	XXX

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93979	TC	A	Vascular study	0.00	3.48	3.71	NA	NA	0.01	XXX
93979	26	A	Vascular study	0.44	0.14	0.15	0.14	0.15	0.03	XXX
93980		A	Penile vascular study	1.25	3.01	3.40	NA	NA	0.06	XXX
93980	TC	A	Penile vascular study	0.00	2.59	2.92	NA	NA	0.01	XXX
93980	26	A	Penile vascular study	1.25	0.42	0.48	0.42	0.48	0.05	XXX
93981		A	Penile vascular study	0.44	2.32	2.76	NA	NA	0.03	XXX
93981	TC	A	Penile vascular study	0.00	2.18	2.60	NA	NA	0.01	XXX
93981	26	A	Penile vascular study	0.44	0.14	0.16	0.14	0.16	0.02	XXX
93982		R	Aneurysm pressure sens study	0.30	0.76	0.80	NA	NA	0.04	XXX
93990		A	Doppler flow testing	0.25	5.14	4.99	NA	NA	0.04	XXX
93990	TC	A	Doppler flow testing	0.00	5.06	4.92	NA	NA	0.01	XXX
93990	26	A	Doppler flow testing	0.25	0.08	0.07	0.08	0.07	0.03	XXX
94002		A	Vent mgmt inpat, init day	1.99	NA	NA	0.46	0.38	0.12	XXX
94003		A	Vent mgmt inpat, subq day	1.37	NA	NA	0.40	0.35	0.08	XXX
94004		A	Vent mgmt nf per day	1.00	NA	NA	0.28	0.26	0.05	XXX
94005		B	Home vent mgmt supervision	1.50	0.92	0.91	NA	NA	0.08	XXX
94010		A	Breathing capacity test	0.17	0.70	0.72	NA	NA	0.03	XXX
94010	TC	A	Breathing capacity test	0.00	0.64	0.67	NA	NA	0.02	XXX
94010	26	A	Breathing capacity test	0.17	0.06	0.05	0.06	0.05	0.01	XXX
94011		A	Up to 2 yrs old, spirometry	2.00	0.62	0.62	0.62	0.62	0.05	XXX
94012		A	= 2 yrs, spiromtry w/dilator	3.10	0.94	0.94	0.94	0.94	0.08	XXX
94013		A	= 2 yrs, lung volumes	0.66	0.18	0.18	0.18	0.18	0.03	XXX
94014		A	Patient recorded spirometry	0.52	0.73	0.79	NA	NA	0.02	XXX
94015		A	Patient recorded spirometry	0.00	0.57	0.63	NA	NA	0.01	XXX
94016		A	Review patient spirometry	0.52	0.16	0.16	0.16	0.16	0.01	XXX
94060		A	Evaluation of wheezing	0.31	1.20	1.24	NA	NA	0.02	XXX
94060	TC	A	Evaluation of wheezing	0.00	1.10	1.15	NA	NA	0.01	XXX
94060	26	A	Evaluation of wheezing	0.31	0.10	0.09	0.10	0.09	0.01	XXX
94070		A	Evaluation of wheezing	0.60	0.93	0.95	NA	NA	0.03	XXX
94070	TC	A	Evaluation of wheezing	0.00	0.74	0.78	NA	NA	0.01	XXX
94070	26	A	Evaluation of wheezing	0.60	0.19	0.17	0.19	0.17	0.02	XXX
94150		B	Vital capacity test	0.07	0.52	0.54	NA	NA	0.02	XXX
94150	TC	B	Vital capacity test	0.00	0.49	0.51	NA	NA	0.01	XXX
94150	26	B	Vital capacity test	0.07	0.03	0.03	0.03	0.03	0.01	XXX
94200		A	Lung function test (MBC/MVV)	0.11	0.47	0.49	NA	NA	0.02	XXX
94200	TC	A	Lung function test (MBC/MVV)	0.00	0.44	0.46	NA	NA	0.01	XXX
94200	26	A	Lung function test	0.11	0.03	0.03	0.03	0.03	0.01	XXX

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			(MBC/MVV)							
94240		A	Residual lung capacity	0.26	0.72	0.76	NA	NA	0.02	XXX
94240	TC	A	Residual lung capacity	0.00	0.64	0.69	NA	NA	0.01	XXX
94240	26	A	Residual lung capacity	0.26	0.08	0.07	0.08	0.07	0.01	XXX
94250		A	Expired gas collection	0.11	0.47	0.53	NA	NA	0.02	XXX
94250	TC	A	Expired gas collection	0.00	0.44	0.50	NA	NA	0.01	XXX
94250	26	A	Expired gas collection	0.11	0.03	0.03	0.03	0.03	0.01	XXX
94260		A	Thoracic gas volume	0.13	0.65	0.69	NA	NA	0.02	XXX
94260	TC	A	Thoracic gas volume	0.00	0.61	0.66	NA	NA	0.01	XXX
94260	26	A	Thoracic gas volume	0.13	0.04	0.03	0.04	0.03	0.01	XXX
94350		A	Lung nitrogen washout curve	0.26	0.58	0.64	NA	NA	0.02	XXX
94350	TC	A	Lung nitrogen washout curve	0.00	0.50	0.57	NA	NA	0.01	XXX
94350	26	A	Lung nitrogen washout curve	0.26	0.08	0.07	0.08	0.07	0.01	XXX
94360		A	Measure airflow resistance	0.26	0.84	0.87	NA	NA	0.02	XXX
94360	TC	A	Measure airflow resistance	0.00	0.76	0.80	NA	NA	0.01	XXX
94360	26	A	Measure airflow resistance	0.26	0.08	0.07	0.08	0.07	0.01	XXX
94370		A	Breath airway closing volume	0.26	0.57	0.62	NA	NA	0.02	XXX
94370	TC	A	Breath airway closing volume	0.00	0.49	0.55	NA	NA	0.01	XXX
94370	26	A	Breath airway closing volume	0.26	0.08	0.07	0.08	0.07	0.01	XXX
94375		A	Respiratory flow volume loop	0.31	0.65	0.69	NA	NA	0.02	XXX
94375	TC	A	Respiratory flow volume loop	0.00	0.56	0.60	NA	NA	0.01	XXX
94375	26	A	Respiratory flow volume loop	0.31	0.09	0.09	0.09	0.09	0.01	XXX
94400		A	CO2 breathing response curve	0.40	0.94	0.98	NA	NA	0.02	XXX
94400	TC	A	CO2 breathing response curve	0.00	0.83	0.87	NA	NA	0.01	XXX
94400	26	A	CO2 breathing response curve	0.40	0.11	0.11	0.11	0.11	0.01	XXX
94450		A	Hypoxia response curve	0.40	1.34	1.06	NA	NA	0.02	XXX
94450	TC	A	Hypoxia response curve	0.00	1.19	0.95	NA	NA	0.01	XXX
94450	26	A	Hypoxia response curve	0.40	0.15	0.11	0.15	0.11	0.01	XXX
94452		A	Hast w/report	0.31	1.07	1.17	NA	NA	0.02	XXX
94452	TC	A	Hast w/report	0.00	0.98	1.09	NA	NA	0.01	XXX
94452	26	A	Hast w/report	0.31	0.09	0.08	0.09	0.08	0.01	XXX
94453		A	Hast w/oxygen titrate	0.40	1.48	1.60	NA	NA	0.02	XXX
94453	TC	A	Hast w/oxygen titrate	0.00	1.37	1.49	NA	NA	0.01	XXX
94453	26	A	Hast w/oxygen titrate	0.40	0.11	0.11	0.11	0.11	0.01	XXX
94610		A	Surfactant admin thru tube	1.16	0.46	0.40	0.46	0.40	0.05	XXX
94620		A	Pulmonary stress test/simple	0.64	0.75	1.12	NA	NA	0.03	XXX
94620	TC	A	Pulmonary stress test/simple	0.00	0.56	0.93	NA	NA	0.01	XXX
94620	26	A	Pulmonary stress test/simple	0.64	0.19	0.19	0.19	0.19	0.02	XXX
94621		A	Pulm stress test/complex	1.42	2.64	2.87	NA	NA	0.05	XXX

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94621	TC	A	Pulm stress test/complex	0.00	2.20	2.40	NA	NA	0.02	XXX
94621	26	A	Pulm stress test/complex	1.42	0.44	0.47	0.44	0.47	0.03	XXX
94640		A	Airway inhalation treatment	0.00	0.41	0.37	NA	NA	0.01	XXX
94642		C	Aerosol inhalation treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94644		A	Cbt, 1st hour	0.00	1.01	0.96	NA	NA	0.01	XXX
94645		A	Cbt, each addl hour	0.00	0.32	0.35	NA	NA	0.01	XXX
94660		A	Pos airway pressure, CPAP	0.76	0.80	0.77	0.24	0.21	0.04	XXX
94662		A	Neg press ventilation, cnp	0.76	NA	NA	0.20	0.20	0.04	XXX
94664		A	Evaluate pt use of inhaler	0.00	0.40	0.38	NA	NA	0.01	XXX
94667		A	Chest wall manipulation	0.00	0.54	0.53	NA	NA	0.01	XXX
94668		A	Chest wall manipulation	0.00	0.53	0.52	NA	NA	0.01	XXX
94680		A	Exhaled air analysis, o2	0.26	1.10	1.25	NA	NA	0.02	XXX
94680	TC	A	Exhaled air analysis, o2	0.00	1.01	1.17	NA	NA	0.01	XXX
94680	26	A	Exhaled air analysis, o2	0.26	0.09	0.08	0.09	0.08	0.01	XXX
94681		A	Exhaled air analysis, o2/co2	0.20	1.05	1.35	NA	NA	0.02	XXX
94681	TC	A	Exhaled air analysis, o2/co2	0.00	0.98	1.29	NA	NA	0.01	XXX
94681	26	A	Exhaled air analysis, o2/co2	0.20	0.07	0.06	0.07	0.06	0.01	XXX
94690		A	Exhaled air analysis	0.07	1.10	1.25	NA	NA	0.02	XXX
94690	TC	A	Exhaled air analysis	0.00	1.07	1.23	NA	NA	0.01	XXX
94690	26	A	Exhaled air analysis	0.07	0.03	0.02	0.03	0.02	0.01	XXX
94720		A	Monoxide diffusing capacity	0.26	1.00	1.08	NA	NA	0.02	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	0.92	1.01	NA	NA	0.01	XXX
94720	26	A	Monoxide diffusing capacity	0.26	0.08	0.07	0.08	0.07	0.01	XXX
94725		A	Membrane diffusion capacity	0.26	0.94	1.35	NA	NA	0.02	XXX
94725	TC	A	Membrane diffusion capacity	0.00	0.86	1.28	NA	NA	0.01	XXX
94725	26	A	Membrane diffusion capacity	0.26	0.08	0.07	0.08	0.07	0.01	XXX
94750		A	Pulmonary compliance study	0.23	1.72	1.71	NA	NA	0.02	XXX
94750	TC	A	Pulmonary compliance study	0.00	1.65	1.65	NA	NA	0.01	XXX
94750	26	A	Pulmonary compliance study	0.23	0.07	0.06	0.07	0.06	0.01	XXX
94760		T	Measure blood oxygen level	0.00	0.06	0.06	NA	NA	0.01	XXX
94761		T	Measure blood oxygen level	0.00	0.10	0.10	NA	NA	0.01	XXX
94762		A	Measure blood oxygen level	0.00	0.26	0.61	NA	NA	0.01	XXX
94770		A	Exhaled carbon dioxide test	0.15	0.82	0.78	NA	NA	0.02	XXX
94770	TC	A	Exhaled carbon dioxide test	0.00	0.77	0.74	NA	NA	0.01	XXX
94770	26	A	Exhaled carbon dioxide test	0.15	0.05	0.04	0.05	0.04	0.01	XXX
94772		C	Breath recording, infant	0.00	0.00	0.00	NA	NA	0.00	XXX
94772	TC	C	Breath recording, infant	0.00	0.00	0.00	NA	NA	0.00	XXX
94772	26	C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94774		C	Ped home apnea rec, compl	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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94775		C	Ped home apnea rec, hk-up	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94776		C	Ped home apnea rec, downld	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94777		C	Ped home apnea rec, report	0.00	0.00	0.00	0.00	0.00	0.00	YYY
94799		C	Pulmonary service/procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
94799	TC	C	Pulmonary service/procedure	0.00	0.00	0.00	NA	NA	0.00	XXX
94799	26	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95004		A	Percut allergy skin tests	0.01	0.14	0.14	NA	NA	0.01	XXX
95010		A	Percut allergy titrate test	0.15	0.31	0.32	NA	NA	0.01	XXX
95012		A	Exhaled nitric oxide meas	0.00	0.47	0.52	NA	NA	0.01	XXX
95015		A	Id allergy titrate-drug/bug	0.15	0.20	0.20	NA	NA	0.01	XXX
95024		A	Id allergy test, drug/bug	0.01	0.16	0.17	NA	NA	0.01	XXX
95027		A	Id allergy titrate-airborne	0.01	0.10	0.11	NA	NA	0.01	XXX
95028		A	Id allergy test-delayed type	0.00	0.32	0.30	NA	NA	0.01	XXX
95044		A	Allergy patch tests	0.00	0.13	0.15	NA	NA	0.01	XXX
95052		A	Photo patch test	0.00	0.14	0.17	NA	NA	0.01	XXX
95056		A	Photosensitivity tests	0.00	1.03	0.98	NA	NA	0.01	XXX
95060		A	Eye allergy tests	0.00	0.78	0.67	0.78	0.67	0.01	XXX
95065		A	Nose allergy test	0.00	0.60	0.59	0.60	0.59	0.01	XXX
95070		A	Bronchial allergy tests	0.00	0.68	1.06	NA	NA	0.01	XXX
95071		A	Bronchial allergy tests	0.00	0.83	1.31	NA	NA	0.01	XXX
95075		A	Ingestion challenge test	0.95	0.75	0.75	0.35	0.33	0.03	XXX
95115		A	Immunotherapy, one injection	0.00	0.22	0.26	NA	NA	0.01	XXX
95117		A	Immunotherapy injections	0.00	0.26	0.32	NA	NA	0.01	XXX
95120		I	Immunotherapy, one injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95125		I	Immunotherapy, many antigens	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95130		I	Immunotherapy, insect venom	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95131		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95132		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95133		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95134		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95144		A	Antigen therapy services	0.06	0.25	0.25	0.02	0.02	0.01	XXX
95145		A	Antigen therapy services	0.06	0.32	0.35	0.02	0.02	0.01	XXX
95146		A	Antigen therapy services	0.06	0.59	0.62	0.02	0.02	0.01	XXX
95147		A	Antigen therapy services	0.06	0.58	0.60	0.02	0.02	0.01	XXX
95148		A	Antigen therapy services	0.06	0.86	0.88	0.02	0.02	0.01	XXX
95149		A	Antigen therapy services	0.06	1.14	1.17	0.02	0.02	0.01	XXX
95165		A	Antigen therapy services	0.06	0.25	0.26	0.02	0.02	0.01	XXX
95170		A	Antigen therapy services	0.06	0.18	0.18	0.02	0.02	0.01	XXX
95180		A	Rapid desensitization	2.01	1.61	1.78	0.82	0.87	0.06	XXX

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95199		C	Allergy immunology services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95250		A	Glucose monitoring, cont	0.00	3.56	3.61	NA	NA	0.01	XXX
95251		A	Gluc monitor, cont, phys i&r	0.85	0.34	0.26	0.34	0.26	0.04	XXX
95803		C	Actigraphy testing	0.00	0.00	0.00	NA	NA	0.00	XXX
95803	TC	C	Actigraphy testing	0.00	0.00	0.00	NA	NA	0.00	XXX
95803	26	C	Actigraphy testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95805		A	Multiple sleep latency test	1.88	6.33	8.76	NA	NA	0.09	XXX
95805	TC	A	Multiple sleep latency test	0.00	5.73	8.18	NA	NA	0.04	XXX
95805	26	A	Multiple sleep latency test	1.88	0.60	0.58	0.60	0.58	0.05	XXX
95806		A	Sleep study unatt&resp efft	1.66	3.73	3.81	NA	NA	0.07	XXX
95806	TC	A	Sleep study unatt&resp efft	0.00	3.18	3.29	NA	NA	0.03	XXX
95806	26	A	Sleep study unatt&resp efft	1.66	0.55	0.52	0.55	0.52	0.04	XXX
95807		A	Sleep study, attended	1.66	9.54	11.21	NA	NA	0.13	XXX
95807	TC	A	Sleep study, attended	0.00	9.03	10.71	NA	NA	0.09	XXX
95807	26	A	Sleep study, attended	1.66	0.51	0.50	0.51	0.50	0.04	XXX
95808		A	Polysomnography, 1-3	2.65	16.26	15.33	NA	NA	0.17	XXX
95808	TC	A	Polysomnography, 1-3	0.00	15.36	14.51	NA	NA	0.09	XXX
95808	26	A	Polysomnography, 1-3	2.65	0.90	0.82	0.90	0.82	0.08	XXX
95810		A	Polysomnography, 4 or more	3.52	15.93	17.14	NA	NA	0.19	XXX
95810	TC	A	Polysomnography, 4 or more	0.00	14.81	16.09	NA	NA	0.10	XXX
95810	26	A	Polysomnography, 4 or more	3.52	1.12	1.05	1.12	1.05	0.09	XXX
95811		A	Polysomnography w/cpap	3.79	17.63	19.00	NA	NA	0.21	XXX
95811	TC	A	Polysomnography w/cpap	0.00	16.44	17.88	NA	NA	0.11	XXX
95811	26	A	Polysomnography w/cpap	3.79	1.19	1.12	1.19	1.12	0.10	XXX
95812		A	Eeg, 41-60 minutes	1.08	8.29	6.12	NA	NA	0.06	XXX
95812	TC	A	Eeg, 41-60 minutes	0.00	7.87	5.75	NA	NA	0.03	XXX
95812	26	A	Eeg, 41-60 minutes	1.08	0.42	0.37	0.42	0.37	0.03	XXX
95813		A	Eeg, over 1 hour	1.73	8.90	6.88	NA	NA	0.08	XXX
95813	TC	A	Eeg, over 1 hour	0.00	8.22	6.29	NA	NA	0.03	XXX
95813	26	A	Eeg, over 1 hour	1.73	0.68	0.59	0.68	0.59	0.05	XXX
95816		A	Eeg, awake and drowsy	1.08	7.51	5.52	NA	NA	0.06	XXX
95816	TC	A	Eeg, awake and drowsy	0.00	7.09	5.15	NA	NA	0.02	XXX
95816	26	A	Eeg, awake and drowsy	1.08	0.42	0.37	0.42	0.37	0.04	XXX
95819		A	Eeg, awake and asleep	1.08	8.70	6.16	NA	NA	0.06	XXX
95819	TC	A	Eeg, awake and asleep	0.00	8.28	5.79	NA	NA	0.03	XXX
95819	26	A	Eeg, awake and asleep	1.08	0.42	0.37	0.42	0.37	0.03	XXX
95822		A	Eeg, coma or sleep only	1.08	7.80	5.89	NA	NA	0.05	XXX
95822	TC	A	Eeg, coma or sleep only	0.00	7.38	5.52	NA	NA	0.02	XXX
95822	26	A	Eeg, coma or sleep only	1.08	0.42	0.37	0.42	0.37	0.03	XXX

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95824		C	Eeg, cerebral death only	0.00	0.00	0.00	NA	NA	0.00	XXX
95824	TC	C	Eeg, cerebral death only	0.00	0.00	0.00	NA	NA	0.00	XXX
95824	26	A	Eeg, cerebral death only	0.74	0.29	0.26	0.29	0.26	0.04	XXX
95827		A	Eeg, all night recording	1.08	16.97	11.23	NA	NA	0.11	XXX
95827	TC	A	Eeg, all night recording	0.00	16.55	10.86	NA	NA	0.08	XXX
95827	26	A	Eeg, all night recording	1.08	0.42	0.37	0.42	0.37	0.03	XXX
95829		A	Surgery electrocorticogram	6.20	35.68	29.28	NA	NA	0.14	XXX
95829	TC	A	Surgery electrocorticogram	0.00	33.19	27.11	NA	NA	0.04	XXX
95829	26	A	Surgery electrocorticogram	6.20	2.49	2.17	2.49	2.17	0.10	XXX
95830		A	Insert electrodes for EEG	1.70	3.76	3.26	0.63	0.57	0.10	XXX
95831		A	Limb muscle testing, manual	0.28	0.49	0.44	0.11	0.10	0.02	XXX
95832		A	Hand muscle testing, manual	0.29	0.47	0.39	0.13	0.11	0.03	XXX
95833		A	Body muscle testing, manual	0.47	0.50	0.49	0.13	0.16	0.01	XXX
95834		A	Body muscle testing, manual	0.60	0.66	0.57	0.20	0.19	0.02	XXX
95851		A	Range of motion measurements	0.16	0.30	0.29	0.05	0.05	0.01	XXX
95852		A	Range of motion measurements	0.11	0.29	0.25	0.04	0.04	0.01	XXX
95857		A	Tensilon test	0.53	0.78	0.64	0.24	0.21	0.03	XXX
95860		A	Muscle test, one limb	0.96	1.54	1.30	NA	NA	0.03	XXX
95860	TC	A	Muscle test, one limb	0.00	1.13	0.93	NA	NA	0.01	XXX
95860	26	A	Muscle test, one limb	0.96	0.41	0.37	0.41	0.37	0.02	XXX
95861		A	Muscle test, 2 limbs	1.54	2.17	1.75	NA	NA	0.05	XXX
95861	TC	A	Muscle test, 2 limbs	0.00	1.52	1.16	NA	NA	0.01	XXX
95861	26	A	Muscle test, 2 limbs	1.54	0.65	0.59	0.65	0.59	0.04	XXX
95863		A	Muscle test, 3 limbs	1.87	2.62	2.07	NA	NA	0.06	XXX
95863	TC	A	Muscle test, 3 limbs	0.00	1.86	1.39	NA	NA	0.01	XXX
95863	26	A	Muscle test, 3 limbs	1.87	0.76	0.68	0.76	0.68	0.05	XXX
95864		A	Muscle test, 4 limbs	1.99	2.82	2.42	NA	NA	0.06	XXX
95864	TC	A	Muscle test, 4 limbs	0.00	2.00	1.68	NA	NA	0.01	XXX
95864	26	A	Muscle test, 4 limbs	1.99	0.82	0.74	0.82	0.74	0.05	XXX
95865		A	Muscle test, larynx	1.57	1.70	1.52	NA	NA	0.04	XXX
95865	TC	A	Muscle test, larynx	0.00	0.99	0.89	NA	NA	0.01	XXX
95865	26	A	Muscle test, larynx	1.57	0.71	0.63	0.71	0.63	0.03	XXX
95866		A	Muscle test, hemidiaphragm	1.25	1.70	1.34	NA	NA	0.05	XXX
95866	TC	A	Muscle test, hemidiaphragm	0.00	1.21	0.86	NA	NA	0.01	XXX
95866	26	A	Muscle test, hemidiaphragm	1.25	0.49	0.48	0.49	0.48	0.04	XXX
95867		A	Muscle test cran nerv unilat	0.79	1.47	1.20	NA	NA	0.03	XXX
95867	TC	A	Muscle test cran nerv unilat	0.00	1.13	0.90	NA	NA	0.01	XXX
95867	26	A	Muscle test cran nerv unilat	0.79	0.34	0.30	0.34	0.30	0.02	XXX
95868		A	Muscle test cran nerve bilat	1.18	1.87	1.53	NA	NA	0.04	XXX

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95868	TC	A	Muscle test cran nerve bilat	0.00	1.38	1.09	NA	NA	0.01	XXX
95868	26	A	Muscle test cran nerve bilat	1.18	0.49	0.44	0.49	0.44	0.03	XXX
95869		A	Muscle test, thor paraspinal	0.37	1.40	0.99	NA	NA	0.02	XXX
95869	TC	A	Muscle test, thor paraspinal	0.00	1.25	0.85	NA	NA	0.01	XXX
95869	26	A	Muscle test, thor paraspinal	0.37	0.15	0.14	0.15	0.14	0.01	XXX
95870		A	Muscle test, nonparaspinal	0.37	1.34	0.95	NA	NA	0.02	XXX
95870	TC	A	Muscle test, nonparaspinal	0.00	1.19	0.81	NA	NA	0.01	XXX
95870	26	A	Muscle test, nonparaspinal	0.37	0.15	0.14	0.15	0.14	0.01	XXX
95872		A	Muscle test, one fiber	2.88	2.16	1.72	NA	NA	0.09	XXX
95872	TC	A	Muscle test, one fiber	0.00	1.02	0.78	NA	NA	0.01	XXX
95872	26	A	Muscle test, one fiber	2.88	1.14	0.94	1.14	0.94	0.08	XXX
95873		A	Guide nerv destr, elec stim	0.37	1.35	0.99	NA	NA	0.02	ZZZ
95873	TC	A	Guide nerv destr, elec stim	0.00	1.17	0.82	NA	NA	0.01	ZZZ
95873	26	A	Guide nerv destr, elec stim	0.37	0.18	0.17	0.18	0.17	0.01	ZZZ
95874		A	Guide nerv destr, needle emg	0.37	1.28	0.92	NA	NA	0.02	ZZZ
95874	TC	A	Guide nerv destr, needle emg	0.00	1.12	0.77	NA	NA	0.01	ZZZ
95874	26	A	Guide nerv destr, needle emg	0.37	0.16	0.15	0.16	0.15	0.01	ZZZ
95875		A	Limb exercise test	1.10	1.85	1.49	NA	NA	0.04	XXX
95875	TC	A	Limb exercise test	0.00	1.42	1.10	NA	NA	0.01	XXX
95875	26	A	Limb exercise test	1.10	0.43	0.39	0.43	0.39	0.03	XXX
95900		A	Motor nerve conduction test	0.42	1.21	1.06	NA	NA	0.02	XXX
95900	TC	A	Motor nerve conduction test	0.00	1.03	0.90	NA	NA	0.01	XXX
95900	26	A	Motor nerve conduction test	0.42	0.18	0.16	0.18	0.16	0.01	XXX
95903		A	Motor nerve conduction test	0.60	1.29	1.13	NA	NA	0.03	XXX
95903	TC	A	Motor nerve conduction test	0.00	1.05	0.92	NA	NA	0.01	XXX
95903	26	A	Motor nerve conduction test	0.60	0.24	0.21	0.24	0.21	0.02	XXX
95904		A	Sense nerve conduction test	0.34	1.09	0.97	NA	NA	0.02	XXX
95904	TC	A	Sense nerve conduction test	0.00	0.95	0.84	NA	NA	0.01	XXX
95904	26	A	Sense nerve conduction test	0.34	0.14	0.13	0.14	0.13	0.01	XXX
95905		A	Motor/sens nrve conduct test	0.05	2.04	2.04	NA	NA	0.02	XXX
95905	TC	A	Motor/sens nrve conduct test	0.00	2.02	2.02	NA	NA	0.01	XXX
95905	26	A	Motor/sens nrve conduct test	0.05	0.02	0.02	0.02	0.02	0.01	XXX
95920		A	Intraop nerve test add-on	2.11	2.23	1.95	NA	NA	0.07	ZZZ
95920	TC	A	Intraop nerve test add-on	0.00	1.39	1.20	NA	NA	0.01	ZZZ
95920	26	A	Intraop nerve test add-on	2.11	0.84	0.75	0.84	0.75	0.06	ZZZ
95921		A	Autonomic nerv function test	0.90	1.27	1.13	NA	NA	0.03	XXX
95921	TC	A	Autonomic nerv function test	0.00	0.94	0.82	NA	NA	0.01	XXX
95921	26	A	Autonomic nerv function test	0.90	0.33	0.31	0.33	0.31	0.02	XXX
95922		A	Autonomic nerv function test	0.96	1.76	1.50	NA	NA	0.03	XXX

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95922	TC	A	Autonomic nerv function test	0.00	1.40	1.17	NA	NA	0.01	XXX
95922	26	A	Autonomic nerv function test	0.96	0.36	0.33	0.36	0.33	0.02	XXX
95923		A	Autonomic nerv function test	0.90	3.20	2.49	NA	NA	0.04	XXX
95923	TC	A	Autonomic nerv function test	0.00	2.85	2.17	NA	NA	0.01	XXX
95923	26	A	Autonomic nerv function test	0.90	0.35	0.32	0.35	0.32	0.03	XXX
95925		A	Somatosensory testing	0.54	4.06	3.00	NA	NA	0.03	XXX
95925	TC	A	Somatosensory testing	0.00	3.85	2.81	NA	NA	0.02	XXX
95925	26	A	Somatosensory testing	0.54	0.21	0.19	0.21	0.19	0.01	XXX
95926		A	Somatosensory testing	0.54	3.92	2.92	NA	NA	0.03	XXX
95926	TC	A	Somatosensory testing	0.00	3.71	2.73	NA	NA	0.02	XXX
95926	26	A	Somatosensory testing	0.54	0.21	0.19	0.21	0.19	0.01	XXX
95927		A	Somatosensory testing	0.54	3.37	2.84	NA	NA	0.03	XXX
95927	TC	A	Somatosensory testing	0.00	3.16	2.64	NA	NA	0.02	XXX
95927	26	A	Somatosensory testing	0.54	0.21	0.20	0.21	0.20	0.01	XXX
95928		A	C motor evoked, uppr limbs	1.50	5.28	4.04	NA	NA	0.07	XXX
95928	TC	A	C motor evoked, uppr limbs	0.00	4.69	3.52	NA	NA	0.02	XXX
95928	26	A	C motor evoked, uppr limbs	1.50	0.59	0.52	0.59	0.52	0.05	XXX
95929		A	C motor evoked, lwr limbs	1.50	5.70	4.36	NA	NA	0.07	XXX
95929	TC	A	C motor evoked, lwr limbs	0.00	5.11	3.83	NA	NA	0.02	XXX
95929	26	A	C motor evoked, lwr limbs	1.50	0.59	0.53	0.59	0.53	0.05	XXX
95930		A	Visual evoked potential test	0.35	3.41	2.74	NA	NA	0.02	XXX
95930	TC	A	Visual evoked potential test	0.00	3.26	2.61	NA	NA	0.01	XXX
95930	26	A	Visual evoked potential test	0.35	0.15	0.13	0.15	0.13	0.01	XXX
95933		A	Blink reflex test	0.59	1.55	1.21	NA	NA	0.03	XXX
95933	TC	A	Blink reflex test	0.00	1.31	1.00	NA	NA	0.01	XXX
95933	26	A	Blink reflex test	0.59	0.24	0.21	0.24	0.21	0.02	XXX
95934		A	H-reflex test	0.51	1.12	0.86	NA	NA	0.02	XXX
95934	TC	A	H-reflex test	0.00	0.91	0.67	NA	NA	0.01	XXX
95934	26	A	H-reflex test	0.51	0.21	0.19	0.21	0.19	0.01	XXX
95936		A	H-reflex test	0.55	0.75	0.62	NA	NA	0.02	XXX
95936	TC	A	H-reflex test	0.00	0.53	0.42	NA	NA	0.01	XXX
95936	26	A	H-reflex test	0.55	0.22	0.20	0.22	0.20	0.01	XXX
95937		A	Neuromuscular junction test	0.65	1.15	0.91	NA	NA	0.04	XXX
95937	TC	A	Neuromuscular junction test	0.00	0.89	0.68	NA	NA	0.01	XXX
95937	26	A	Neuromuscular junction test	0.65	0.26	0.23	0.26	0.23	0.03	XXX
95950		A	Ambulatory eeg monitoring	1.51	6.87	5.22	NA	NA	0.06	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	6.28	4.70	NA	NA	0.02	XXX
95950	26	A	Ambulatory eeg monitoring	1.51	0.59	0.52	0.59	0.52	0.04	XXX
95951		C	EEG monitoring/videorecord	0.00	0.00	0.00	NA	NA	0.00	XXX

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95951	TC	C	EEG monitoring/videorecord	0.00	0.00	0.00	NA	NA	0.00	XXX
95951	26	A	EEG monitoring/videorecord	5.99	2.36	2.09	2.36	2.09	0.35	XXX
95953		A	EEG monitoring/computer	3.30	10.33	8.08	NA	NA	0.14	XXX
95953	TC	A	EEG monitoring/computer	0.00	9.03	6.95	NA	NA	0.03	XXX
95953	26	A	EEG monitoring/computer	3.30	1.30	1.13	1.30	1.13	0.11	XXX
95954		A	EEG monitoring/giving drugs	2.45	6.13	4.69	NA	NA	0.12	XXX
95954	TC	A	EEG monitoring/giving drugs	0.00	5.48	4.10	NA	NA	0.04	XXX
95954	26	A	EEG monitoring/giving drugs	2.45	0.65	0.59	0.65	0.59	0.08	XXX
95955		A	EEG during surgery	1.01	3.75	2.90	NA	NA	0.04	XXX
95955	TC	A	EEG during surgery	0.00	3.36	2.57	NA	NA	0.01	XXX
95955	26	A	EEG during surgery	1.01	0.39	0.33	0.39	0.33	0.03	XXX
95956		A	Eeg monitoring, cable/radio	3.08	18.26	16.65	NA	NA	0.23	XXX
95956	TC	A	Eeg monitoring, cable/radio	0.00	17.11	15.59	NA	NA	0.14	XXX
95956	26	A	Eeg monitoring, cable/radio	3.08	1.15	1.06	1.15	1.06	0.09	XXX
95957		A	EEG digital analysis	1.98	8.11	5.80	NA	NA	0.08	XXX
95957	TC	A	EEG digital analysis	0.00	7.34	5.11	NA	NA	0.02	XXX
95957	26	A	EEG digital analysis	1.98	0.77	0.69	0.77	0.69	0.06	XXX
95958		A	EEG monitoring/function test	4.24	8.81	6.73	NA	NA	0.17	XXX
95958	TC	A	EEG monitoring/function test	0.00	7.24	5.26	NA	NA	0.04	XXX
95958	26	A	EEG monitoring/function test	4.24	1.57	1.47	1.57	1.47	0.13	XXX
95961		A	Electrode stimulation, brain	2.97	4.15	3.26	NA	NA	0.10	XXX
95961	TC	A	Electrode stimulation, brain	0.00	2.95	2.18	NA	NA	0.01	XXX
95961	26	A	Electrode stimulation, brain	2.97	1.20	1.08	1.20	1.08	0.09	XXX
95962		A	Electrode stim, brain add-on	3.21	3.09	2.53	NA	NA	0.11	ZZZ
95962	TC	A	Electrode stim, brain add-on	0.00	1.81	1.41	NA	NA	0.01	ZZZ
95962	26	A	Electrode stim, brain add-on	3.21	1.28	1.12	1.28	1.12	0.10	ZZZ
95965		C	Meg, spontaneous	0.00	0.00	0.00	NA	NA	0.00	XXX
95965	TC	C	Meg, spontaneous	0.00	0.00	0.00	NA	NA	0.00	XXX
95965	26	A	Meg, spontaneous	7.99	3.15	2.98	3.15	2.98	0.46	XXX
95966		C	Meg, evoked, single	0.00	0.00	0.00	NA	NA	0.00	XXX
95966	TC	C	Meg, evoked, single	0.00	0.00	0.00	NA	NA	0.00	XXX
95966	26	A	Meg, evoked, single	3.99	1.57	1.50	1.57	1.50	0.23	XXX
95967		C	Meg, evoked, each addl	0.00	0.00	0.00	NA	NA	0.00	ZZZ
95967	TC	C	Meg, evoked, each addl	0.00	0.00	0.00	NA	NA	0.00	ZZZ
95967	26	A	Meg, evoked, each addl	3.49	1.38	1.23	1.38	1.23	0.20	ZZZ
95970		A	Analyze neurostim, no prog	0.45	1.19	0.97	0.18	0.14	0.03	XXX
95971		A	Analyze neurostim, simple	0.78	0.68	0.72	0.27	0.27	0.05	XXX
95972		A	Analyze neurostim, complex	1.50	1.30	1.22	0.57	0.50	0.11	XXX
95973		A	Analyze neurostim, complex	0.92	0.71	0.59	0.37	0.29	0.06	ZZZ

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95974		A	Cranial neurostim, complex	3.00	2.03	1.68	1.13	1.00	0.18	XXX
95975		A	Cranial neurostim, complex	1.70	1.00	0.85	0.67	0.59	0.09	ZZZ
95978		A	Analyze neurostim brain/1h	3.50	2.58	2.09	1.42	1.22	0.28	XXX
95979		A	Analyz neurostim brain addon	1.64	1.04	0.85	0.67	0.58	0.11	ZZZ
95980		A	Io anal gast n-stim init	0.80	NA	NA	0.34	0.28	0.12	XXX
95981		A	Io anal gast n-stim subsq	0.30	0.50	0.46	0.17	0.13	0.02	XXX
95982		A	Io ga n-stim subsq w/reprog	0.65	0.69	0.55	0.31	0.23	0.05	XXX
95990		A	Spin/brain pump refil & main	0.00	2.12	1.73	NA	NA	0.02	XXX
95991		A	Spin/brain pump refil & main	0.77	2.20	1.76	0.29	0.21	0.05	XXX
95992		I	Canalith repositioning proc	0.75	0.38	0.37	0.27	0.26	0.04	XXX
95999		C	Neurological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96000		A	Motion analysis, video/3d	1.80	NA	NA	0.71	0.55	0.08	XXX
96001		A	Motion test w/ft press meas	2.15	NA	NA	0.76	0.63	0.10	XXX
96002		A	Dynamic surface emg	0.41	NA	NA	0.15	0.14	0.02	XXX
96003		A	Dynamic fine wire emg	0.37	NA	NA	0.15	0.11	0.02	XXX
96004		A	Phys review of motion tests	2.14	0.87	0.82	0.87	0.82	0.11	XXX
96020		C	Functional brain mapping	0.00	0.00	0.00	NA	NA	0.00	XXX
96020	TC	C	Functional brain mapping	0.00	0.00	0.00	NA	NA	0.00	XXX
96020	26	A	Functional brain mapping	3.43	1.03	1.27	1.03	1.27	0.23	XXX
96040		B	Genetic counseling, 30 min	0.00	1.05	1.11	NA	NA	0.01	XXX
96101		A	Psycho testing by psych/phys	1.86	0.24	0.39	0.23	0.38	0.05	XXX
96102		A	Psycho testing by technician	0.50	0.98	0.94	0.10	0.12	0.03	XXX
96103		A	Psycho testing admin by comp	0.51	1.10	0.85	0.15	0.14	0.02	XXX
96105		A	Assessment of aphasia	0.00	2.46	2.04	NA	NA	0.03	XXX
96110		A	Developmental test, lim	0.00	0.20	0.19	NA	NA	0.01	XXX
96111		A	Developmental test, extend	2.60	1.00	0.89	0.87	0.79	0.12	XXX
96116		A	Neurobehavioral status exam	1.86	0.58	0.61	0.45	0.47	0.07	XXX
96118		A	Neuropsych tst by psych/phys	1.86	0.57	0.88	0.21	0.37	0.05	XXX
96119		A	Neuropsych testing by tec	0.55	1.17	1.31	0.07	0.12	0.02	XXX
96120		A	Neuropsych tst admin w/comp	0.51	1.77	1.49	0.14	0.13	0.02	XXX
96125		A	Cognitive test by hc pro	1.70	1.03	0.85	0.61	0.45	0.05	XXX
96150		A	Assess hlth/behave, init	0.50	0.06	0.11	0.05	0.10	0.01	XXX
96151		A	Assess hlth/behave, subseq	0.48	0.06	0.11	0.05	0.10	0.01	XXX
96152		A	Intervene hlth/behave, indiv	0.46	0.06	0.10	0.05	0.09	0.01	XXX
96153		A	Intervene hlth/behave, group	0.10	0.02	0.03	0.01	0.02	0.01	XXX
96154		A	Interv hlth/behav, fam w/pt	0.45	0.05	0.10	0.05	0.09	0.01	XXX
96155		N	Interv hlth/behav fam no pt	0.44	0.16	0.16	0.16	0.16	0.02	XXX
96360		A	Hydration iv infusion, init	0.17	1.13	1.30	NA	NA	0.02	XXX
96361		A	Hydrate iv infusion, add-on	0.09	0.26	0.32	NA	NA	0.01	ZZZ

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96365		A	Ther/proph/diag iv inf, init	0.21	1.43	1.61	NA	NA	0.03	XXX
96366		A	Ther/proph/diag iv inf addon	0.18	0.34	0.38	NA	NA	0.01	ZZZ
96367		A	Tx/proph/dg addl seq iv inf	0.19	0.55	0.70	NA	NA	0.01	ZZZ
96368		A	Ther/diag concurrent inf	0.17	0.29	0.35	NA	NA	0.01	ZZZ
96369		A	Sc ther infusion, up to 1 hr	0.21	3.35	3.81	NA	NA	0.02	XXX
96370		A	Sc ther infusion, addl hr	0.18	0.22	0.22	NA	NA	0.01	ZZZ
96371		A	Sc ther infusion, reset pump	0.00	2.18	2.08	NA	NA	0.01	ZZZ
96372		A	Ther/proph/diag inj, sc/im	0.17	0.42	0.41	NA	NA	0.01	XXX
96373		A	Ther/proph/diag inj, ia	0.17	0.32	0.32	NA	NA	0.01	XXX
96374		A	Ther/proph/diag inj, iv push	0.18	1.09	1.26	NA	NA	0.02	XXX
96375		A	Tx/pro/dx inj new drug addon	0.10	0.41	0.50	NA	NA	0.01	ZZZ
96376		X	Tx/pro/dx inj new drug adon	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
96379		C	Ther/prop/diag inj/inf proc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96401		A	Chemo, anti-neopl, sq/im	0.21	1.48	1.63	NA	NA	0.01	XXX
96402		A	Chemo hormon antineopl sq/im	0.19	0.57	0.77	NA	NA	0.01	XXX
96405		A	Chemo intralesional, up to 7	0.52	1.46	1.74	0.28	0.26	0.02	000
96406		A	Chemo intralesional over 7	0.80	1.99	2.34	0.39	0.35	0.03	000
96409		A	Chemo, iv push, sngl drug	0.24	2.21	2.70	NA	NA	0.04	XXX
96411		A	Chemo, iv push, addl drug	0.20	1.19	1.45	NA	NA	0.02	ZZZ
96413		A	Chemo, iv infusion, 1 hr	0.28	2.87	3.57	NA	NA	0.05	XXX
96415		A	Chemo, iv infusion, addl hr	0.19	0.52	0.64	NA	NA	0.01	ZZZ
96416		A	Chemo prolong infuse w/pump	0.21	3.23	4.00	NA	NA	0.05	XXX
96417		A	Chemo iv infus each addl seq	0.21	1.37	1.69	NA	NA	0.02	ZZZ
96420		A	Chemo, ia, push tecnique	0.17	2.19	2.65	NA	NA	0.06	XXX
96422		A	Chemo ia infusion up to 1 hr	0.17	3.57	4.39	NA	NA	0.06	XXX
96423		A	Chemo ia infuse each addl hr	0.17	1.58	1.90	NA	NA	0.03	ZZZ
96425		A	Chemotherapy,infusion method	0.17	3.83	4.41	NA	NA	0.07	XXX
96440		A	Chemotherapy, intracavitary	2.37	18.32	15.36	1.05	1.13	0.40	000
96445		A	Chemotherapy, intracavitary	2.20	4.34	5.35	0.94	0.93	0.14	000
96450		A	Chemotherapy, into CNS	1.53	2.87	3.89	0.62	0.78	0.09	000
96521		A	Refill/maint, portable pump	0.21	2.77	3.18	NA	NA	0.04	XXX
96522		A	Refill/maint pump/resvr syst	0.21	2.30	2.66	NA	NA	0.04	XXX
96523		T	Irrig drug delivery device	0.04	0.51	0.63	NA	NA	0.01	XXX
96542		A	Chemotherapy injection	0.75	1.99	2.72	0.36	0.43	0.04	XXX
96549		C	Chemotherapy, unspecified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96567		A	Photodynamic tx, skin	0.00	3.17	3.25	NA	NA	0.01	XXX
96570		A	Photodynmc tx, 30 min add-on	1.10	0.37	0.40	0.37	0.40	0.13	ZZZ
96571		A	Photodynamic tx, addl 15 min	0.55	0.15	0.18	0.15	0.18	0.03	ZZZ
96900		A	Ultraviolet light therapy	0.00	0.48	0.52	NA	NA	0.01	XXX

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96902		B	Trichogram	0.41	0.17	0.16	0.15	0.14	0.02	XXX
96904		R	Whole body photography	0.00	1.50	1.73	NA	NA	0.01	XXX
96910		A	Photochemotherapy with UV-B	0.00	1.66	1.72	NA	NA	0.01	XXX
96912		A	Photochemotherapy with UV-A	0.00	2.13	2.20	NA	NA	0.01	XXX
96913		A	Photochemotherapy, UV-A or B	0.00	3.00	3.05	NA	NA	0.01	XXX
96920		A	Laser tx, skin < 250 sq cm	1.15	3.18	3.30	0.69	0.62	0.03	000
96921		A	Laser tx, skin 250-500 sq cm	1.17	3.28	3.24	0.68	0.59	0.04	000
96922		A	Laser tx, skin > 500 sq cm	2.10	4.22	4.35	1.26	1.07	0.06	000
96999		C	Dermatological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97001		A	Pt evaluation	1.20	0.77	0.72	NA	NA	0.04	XXX
97002		A	Pt re-evaluation	0.60	0.48	0.44	NA	NA	0.02	XXX
97003		A	Ot evaluation	1.20	1.00	0.86	NA	NA	0.05	XXX
97004		A	Ot re-evaluation	0.60	0.73	0.62	NA	NA	0.02	XXX
97005		I	Athletic train eval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97006		I	Athletic train reeval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97010		B	Hot or cold packs therapy	0.06	0.08	0.07	NA	NA	0.01	XXX
97012		A	Mechanical traction therapy	0.25	0.17	0.15	NA	NA	0.01	XXX
97014		I	Electric stimulation therapy	0.18	0.21	0.19	NA	NA	0.01	XXX
97016		A	Vasopneumatic device therapy	0.18	0.29	0.25	NA	NA	0.01	XXX
97018		A	Paraffin bath therapy	0.06	0.19	0.16	NA	NA	0.01	XXX
97022		A	Whirlpool therapy	0.17	0.40	0.33	NA	NA	0.01	XXX
97024		A	Diathermy eg, microwave	0.06	0.10	0.09	NA	NA	0.01	XXX
97026		A	Infrared therapy	0.06	0.08	0.07	NA	NA	0.01	XXX
97028		A	Ultraviolet therapy	0.08	0.10	0.09	NA	NA	0.01	XXX
97032		A	Electrical stimulation	0.25	0.24	0.20	NA	NA	0.01	XXX
97033		A	Electric current therapy	0.26	0.53	0.44	NA	NA	0.01	XXX
97034		A	Contrast bath therapy	0.21	0.24	0.21	NA	NA	0.01	XXX
97035		A	Ultrasound therapy	0.21	0.12	0.11	NA	NA	0.01	XXX
97036		A	Hydrotherapy	0.28	0.53	0.45	NA	NA	0.02	XXX
97039		C	Physical therapy treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97110		A	Therapeutic exercises	0.45	0.38	0.33	NA	NA	0.01	XXX
97112		A	Neuromuscular reeducation	0.45	0.41	0.36	NA	NA	0.02	XXX
97113		A	Aquatic therapy/exercises	0.44	0.64	0.54	NA	NA	0.01	XXX
97116		A	Gait training therapy	0.40	0.33	0.29	NA	NA	0.01	XXX
97124		A	Massage therapy	0.35	0.32	0.28	NA	NA	0.01	XXX
97139		C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97140		A	Manual therapy	0.43	0.34	0.30	NA	NA	0.01	XXX
97150		A	Group therapeutic procedures	0.27	0.26	0.23	NA	NA	0.01	XXX

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97530		A	Therapeutic activities	0.44	0.45	0.40	NA	NA	0.01	XXX
97532		A	Cognitive skills development	0.44	0.26	0.23	NA	NA	0.01	XXX
97533		A	Sensory integration	0.44	0.32	0.29	NA	NA	0.01	XXX
97535		A	Self care mngment training	0.45	0.44	0.39	NA	NA	0.01	XXX
97537		A	Community/work reintegration	0.45	0.33	0.30	NA	NA	0.01	XXX
97542		A	Wheelchair mngment training	0.45	0.34	0.31	NA	NA	0.01	XXX
97545		R	Work hardening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97546		R	Work hardening add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
97597		A	Active wound care/20 cm or <	0.58	1.33	1.09	0.14	0.23	0.04	XXX
97598		A	Active wound care > 20 cm	0.80	1.54	1.27	0.19	0.30	0.05	XXX
97602		B	Wound(s) care non-selective	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97605		A	Neg press wound tx, < 50 cm	0.55	0.48	0.42	0.13	0.15	0.06	XXX
97606		A	Neg press wound tx, > 50 cm	0.60	0.50	0.43	0.14	0.16	0.08	XXX
97750		A	Physical performance test	0.45	0.39	0.35	NA	NA	0.02	XXX
97755		A	Assistive technology assess	0.62	0.32	0.30	NA	NA	0.02	XXX
97760		A	Orthotic mgmt and training	0.45	0.51	0.44	NA	NA	0.02	XXX
97761		A	Prosthetic training	0.45	0.39	0.34	NA	NA	0.02	XXX
97762		A	C/o for orthotic/prosth use	0.25	0.89	0.72	NA	NA	0.01	XXX
97799		C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97802		A	Medical nutrition, indiv, in	0.53	0.23	0.26	0.19	0.22	0.02	XXX
97803		A	Med nutrition, indiv, subseq	0.45	0.20	0.24	0.16	0.19	0.02	XXX
97804		A	Medical nutrition, group	0.25	0.10	0.10	0.09	0.10	0.01	XXX
97810		N	Acupunct w/o stimul 15 min	0.60	0.35	0.35	0.22	0.22	0.03	XXX
97811		N	Acupunct w/o stimul addl 15m	0.50	0.22	0.22	0.18	0.18	0.03	ZZZ
97813		N	Acupunct w/stimul 15 min	0.65	0.37	0.37	0.24	0.24	0.03	XXX
97814		N	Acupunct w/stimul addl 15m	0.55	0.27	0.27	0.20	0.20	0.03	ZZZ
98925		A	Osteopathic manipulation	0.45	0.37	0.32	0.17	0.14	0.02	000
98926		A	Osteopathic manipulation	0.65	0.47	0.41	0.23	0.21	0.03	000
98927		A	Osteopathic manipulation	0.87	0.58	0.51	0.29	0.26	0.04	000
98928		A	Osteopathic manipulation	1.03	0.65	0.58	0.34	0.31	0.04	000
98929		A	Osteopathic manipulation	1.19	0.76	0.66	0.40	0.36	0.05	000
98940		A	Chiropractic manipulation	0.45	0.25	0.23	0.13	0.12	0.01	000
98941		A	Chiropractic manipulation	0.65	0.31	0.29	0.19	0.18	0.02	000
98942		A	Chiropractic manipulation	0.87	0.38	0.36	0.25	0.25	0.02	000
98943		N	Chiropractic manipulation	0.40	0.23	0.23	0.15	0.14	0.02	XXX
98960		B	Self-mgmt educ & train, 1 pt	0.00	0.62	0.65	NA	NA	0.01	XXX
98961		B	Self-mgmt educ/train, 2-4 pt	0.00	0.30	0.31	NA	NA	0.01	XXX
98962		B	Self-mgmt educ/train, 5-8 pt	0.00	0.22	0.23	NA	NA	0.01	XXX
98966		N	Hc pro phone call 5-10 min	0.25	0.12	0.12	0.09	0.08	0.01	XXX

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98967		N	Hc pro phone call 11-20 min	0.50	0.21	0.21	0.18	0.18	0.03	XXX
98968		N	Hc pro phone call 21-30 min	0.75	0.30	0.29	0.27	0.26	0.04	XXX
98969		N	Online service by hc pro	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99000		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99001		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99002		B	Device handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99024		B	Postop follow-up visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99026		N	In-hospital on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99027		N	Out-of-hosp on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99050		B	Medical services after hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99051		B	Med serv, eve/wkend/holiday	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99053		B	Med serv 10pm-8am, 24 hr fac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99056		B	Med service out of office	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99058		B	Office emergency care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99060		B	Out of office emerg med serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99070		B	Special supplies	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99071		B	Patient education materials	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99075		N	Medical testimony	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99078		B	Group health education	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99080		B	Special reports or forms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99090		B	Computer data analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99091		B	Collect/review data from pt	1.10	0.40	0.38	NA	NA	0.06	XXX
99100		B	Special anesthesia service	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99116		B	Anesthesia with hypothermia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99135		B	Special anesthesia procedure	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99140		B	Emergency anesthesia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99143		C	Mod cs by same phys, < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99144		C	Mod cs by same phys, 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99145		C	Mod cs by same phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99148		C	Mod cs diff phys < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99149		C	Mod cs diff phys 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99150		C	Mod cs diff phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99170		A	Anogenital exam, child	1.75	1.81	2.07	0.70	0.77	0.09	000
99172		N	Ocular function screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99173		N	Visual acuity screen	0.00	0.06	0.06	NA	NA	0.01	XXX
99174		N	Ocular photoscreening	0.00	0.67	0.70	NA	NA	0.01	XXX
99175		A	Induction of vomiting	0.00	0.55	0.61	NA	NA	0.01	XXX
99183		A	Hyperbaric oxygen therapy	2.34	3.08	2.88	0.80	0.69	0.18	XXX

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99190		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99191		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99192		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99195		A	Phlebotomy	0.00	2.08	2.00	NA	NA	0.04	XXX
99199		C	Special service/proc/report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99201		A	Office/outpatient visit, new	0.48	0.61	0.57	0.21	0.18	0.03	XXX
99202		A	Office/outpatient visit, new	0.93	0.97	0.88	0.40	0.35	0.06	XXX
99203		A	Office/outpatient visit, new	1.42	1.31	1.19	0.59	0.50	0.10	XXX
99204		A	Office/outpatient visit, new	2.43	1.80	1.61	1.00	0.82	0.16	XXX
99205		A	Office/outpatient visit, new	3.17	2.10	1.91	1.24	1.05	0.20	XXX
99211		A	Office/outpatient visit, est	0.18	0.31	0.34	0.07	0.06	0.01	XXX
99212		A	Office/outpatient visit, est	0.48	0.61	0.57	0.20	0.17	0.03	XXX
99213		A	Office/outpatient visit, est	0.97	0.88	0.80	0.39	0.32	0.05	XXX
99214		A	Office/outpatient visit, est	1.50	1.24	1.15	0.58	0.49	0.08	XXX
99215		A	Office/outpatient visit, est	2.11	1.59	1.46	0.82	0.70	0.11	XXX
99217		A	Observation care discharge	1.28	NA	NA	0.60	0.54	0.06	XXX
99218		A	Observation care	1.28	NA	NA	0.47	0.42	0.07	XXX
99219		A	Observation care	2.14	NA	NA	0.80	0.69	0.10	XXX
99220		A	Observation care	2.99	NA	NA	1.08	0.97	0.14	XXX
99221		A	Initial hospital care	1.89	NA	NA	0.70	0.59	0.13	XXX
99222		A	Initial hospital care	2.57	NA	NA	0.98	0.81	0.15	XXX
99223		A	Initial hospital care	3.79	NA	NA	1.43	1.19	0.20	XXX
99231		A	Subsequent hospital care	0.76	NA	NA	0.28	0.26	0.04	XXX
99232		A	Subsequent hospital care	1.39	NA	NA	0.52	0.45	0.07	XXX
99233		A	Subsequent hospital care	2.00	NA	NA	0.73	0.64	0.10	XXX
99234		A	Observ/hosp same date	2.56	NA	NA	0.95	0.88	0.15	XXX
99235		A	Observ/hosp same date	3.41	NA	NA	1.27	1.13	0.17	XXX
99236		A	Observ/hosp same date	4.26	NA	NA	1.55	1.38	0.21	XXX
99238		A	Hospital discharge day	1.28	NA	NA	0.61	0.54	0.06	XXX
99239		A	Hospital discharge day	1.90	NA	NA	0.89	0.76	0.08	XXX
99241		I	Office consultation	0.64	0.66	0.66	0.24	0.24	0.05	XXX
99242		I	Office consultation	1.34	1.10	1.10	0.51	0.51	0.10	XXX
99243		I	Office consultation	1.88	1.46	1.46	0.71	0.71	0.13	XXX
99244		I	Office consultation	3.02	1.96	1.96	1.14	1.14	0.16	XXX
99245		I	Office consultation	3.77	2.30	2.30	1.38	1.38	0.21	XXX
99251		I	Inpatient consultation	1.00	NA	NA	0.32	0.32	0.05	XXX
99252		I	Inpatient consultation	1.50	NA	NA	0.52	0.52	0.09	XXX
99253		I	Inpatient consultation	2.27	NA	NA	0.84	0.84	0.11	XXX
99254		I	Inpatient consultation	3.29	NA	NA	1.23	1.23	0.13	XXX

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99255		I	Inpatient consultation	4.00	NA	NA	1.44	1.44	0.18	XXX
99281		A	Emergency dept visit	0.45	NA	NA	0.12	0.10	0.03	XXX
99282		A	Emergency dept visit	0.88	NA	NA	0.23	0.19	0.05	XXX
99283		A	Emergency dept visit	1.34	NA	NA	0.33	0.29	0.08	XXX
99284		A	Emergency dept visit	2.56	NA	NA	0.56	0.50	0.15	XXX
99285		A	Emergency dept visit	3.80	NA	NA	0.76	0.72	0.22	XXX
99288		B	Direct advanced life support	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99291		A	Critical care, first hour	4.50	2.51	2.41	1.37	1.24	0.25	XXX
99292		A	Critical care, addl 30 min	2.25	0.93	0.86	0.69	0.62	0.12	ZZZ
99304		A	Nursing facility care, init	1.61	0.76	0.62	0.76	0.62	0.10	XXX
99305		A	Nursing facility care, init	2.31	1.04	0.82	1.04	0.82	0.14	XXX
99306		A	Nursing facility care, init	3.01	1.28	1.00	1.28	1.00	0.16	XXX
99307		A	Nursing fac care, subseq	0.76	0.41	0.34	0.41	0.34	0.03	XXX
99308		A	Nursing fac care, subseq	1.16	0.64	0.53	0.64	0.53	0.05	XXX
99309		A	Nursing fac care, subseq	1.55	0.83	0.68	0.83	0.68	0.07	XXX
99310		A	Nursing fac care, subseq	2.35	1.17	0.95	1.17	0.95	0.10	XXX
99315		A	Nursing fac discharge day	1.13	0.57	0.47	0.57	0.47	0.05	XXX
99316		A	Nursing fac discharge day	1.50	0.72	0.59	0.72	0.59	0.07	XXX
99318		A	Annual nursing fac assessmnt	1.71	0.82	0.63	0.82	0.63	0.08	XXX
99324		A	Domicil/r-home visit new pat	1.01	0.44	0.45	NA	NA	0.05	XXX
99325		A	Domicil/r-home visit new pat	1.52	0.60	0.60	NA	NA	0.08	XXX
99326		A	Domicil/r-home visit new pat	2.63	1.10	0.94	NA	NA	0.12	XXX
99327		A	Domicil/r-home visit new pat	3.46	1.46	1.20	NA	NA	0.15	XXX
99328		A	Domicil/r-home visit new pat	4.09	1.63	1.38	NA	NA	0.17	XXX
99334		A	Domicil/r-home visit est pat	1.07	0.52	0.46	NA	NA	0.05	XXX
99335		A	Domicil/r-home visit est pat	1.72	0.78	0.66	NA	NA	0.08	XXX
99336		A	Domicil/r-home visit est pat	2.46	1.10	0.89	NA	NA	0.11	XXX
99337		A	Domicil/r-home visit est pat	3.58	1.54	1.23	NA	NA	0.16	XXX
99339		B	Domicil/r-home care supervis	1.25	0.77	0.76	NA	NA	0.06	XXX
99340		B	Domicil/r-home care supervis	1.80	1.03	1.02	NA	NA	0.09	XXX
99341		A	Home visit, new patient	1.01	0.43	0.45	NA	NA	0.06	XXX
99342		A	Home visit, new patient	1.52	0.57	0.59	NA	NA	0.08	XXX
99343		A	Home visit, new patient	2.53	0.96	0.91	NA	NA	0.13	XXX
99344		A	Home visit, new patient	3.38	1.43	1.19	NA	NA	0.15	XXX
99345		A	Home visit, new patient	4.09	1.72	1.41	NA	NA	0.18	XXX
99347		A	Home visit, est patient	1.00	0.46	0.44	NA	NA	0.05	XXX
99348		A	Home visit, est patient	1.56	0.67	0.61	NA	NA	0.08	XXX
99349		A	Home visit, est patient	2.33	1.05	0.86	NA	NA	0.11	XXX
99350		A	Home visit, est patient	3.28	1.43	1.16	NA	NA	0.15	XXX

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99354		A	Prolonged service, office	1.77	0.83	0.74	0.67	0.60	0.09	ZZZ
99355		A	Prolonged service, office	1.77	0.79	0.72	0.63	0.57	0.09	ZZZ
99356		A	Prolonged service, inpatient	1.71	NA	NA	0.69	0.59	0.08	ZZZ
99357		A	Prolonged service, inpatient	1.71	NA	NA	0.69	0.59	0.08	ZZZ
99358		B	Prolong service w/o contact	2.10	0.80	0.77	0.80	0.77	0.11	XXX
99359		B	Prolong serv w/o contact add	1.00	0.40	0.38	0.40	0.38	0.05	ZZZ
99360		X	Physician standby services	1.20	NA	NA	0.44	0.42	0.06	XXX
99363		B	Anticoag mgmt, init	1.65	1.58	1.59	0.60	0.57	0.08	XXX
99364		B	Anticoag mgmt, subseq	0.63	0.48	0.48	0.23	0.22	0.03	XXX
99366		B	Team conf w/pat by hc pro	0.82	0.32	0.30	0.30	0.28	0.04	XXX
99367		B	Team conf w/o pat by phys	1.10	NA	NA	0.40	0.38	0.06	XXX
99368		B	Team conf w/o pat by hc pro	0.72	NA	NA	0.26	0.25	0.04	XXX
99374		B	Home health care supervision	1.10	0.71	0.71	0.40	0.39	0.06	XXX
99375		I	Home health care supervision	1.73	1.00	1.10	0.63	0.79	0.09	XXX
99377		B	Hospice care supervision	1.10	0.71	0.71	0.40	0.39	0.06	XXX
99378		I	Hospice care supervision	1.73	1.00	1.18	0.63	0.86	0.09	XXX
99379		B	Nursing fac care supervision	1.10	0.71	0.71	0.40	0.39	0.06	XXX
99380		B	Nursing fac care supervision	1.73	1.00	1.00	0.63	0.62	0.09	XXX
99381		N	Init pm e/m, new pat, inf	1.19	1.20	1.27	0.43	0.42	0.06	XXX
99382		N	Init pm e/m, new pat 1-4 yrs	1.36	1.26	1.33	0.50	0.48	0.07	XXX
99383		N	Prev visit, new, age 5-11	1.36	1.26	1.31	0.50	0.48	0.07	XXX
99384		N	Prev visit, new, age 12-17	1.53	1.32	1.37	0.56	0.55	0.08	XXX
99385		N	Prev visit, new, age 18-39	1.53	1.32	1.37	0.56	0.55	0.08	XXX
99386		N	Prev visit, new, age 40-64	1.88	1.45	1.51	0.69	0.67	0.09	XXX
99387		N	Init pm e/m, new pat 65+ yrs	2.06	1.61	1.67	0.75	0.74	0.10	XXX
99391		N	Per pm reeval, est pat, inf	1.02	1.04	1.05	0.37	0.36	0.05	XXX
99392		N	Prev visit, est, age 1-4	1.19	1.10	1.11	0.43	0.42	0.06	XXX
99393		N	Prev visit, est, age 5-11	1.19	1.09	1.10	0.43	0.42	0.06	XXX
99394		N	Prev visit, est, age 12-17	1.36	1.15	1.16	0.50	0.48	0.07	XXX
99395		N	Prev visit, est, age 18-39	1.36	1.16	1.17	0.50	0.48	0.07	XXX
99396		N	Prev visit, est, age 40-64	1.53	1.22	1.23	0.56	0.55	0.08	XXX
99397		N	Per pm reeval est pat 65+ yr	1.71	1.39	1.40	0.62	0.62	0.09	XXX
99401		N	Preventive counseling, indiv	0.48	0.44	0.48	0.18	0.17	0.02	XXX
99402		N	Preventive counseling, indiv	0.98	0.62	0.67	0.36	0.35	0.05	XXX
99403		N	Preventive counseling, indiv	1.46	0.80	0.85	0.53	0.52	0.07	XXX
99404		N	Preventive counseling, indiv	1.95	0.98	1.03	0.71	0.70	0.10	XXX
99406		A	Behav chng smoking 3-10 min	0.24	0.13	0.12	0.09	0.08	0.01	XXX
99407		A	Behav chng smoking > 10 min	0.50	0.23	0.19	0.18	0.16	0.02	XXX
99408		N	Audit/dast, 15-30 min	0.65	0.28	0.27	0.24	0.23	0.03	XXX

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99409		N	Audit/dast, over 30 min	1.30	0.52	0.50	0.47	0.46	0.07	XXX
99411		N	Preventive counseling, group	0.15	0.25	0.25	0.05	0.05	0.01	XXX
99412		N	Preventive counseling, group	0.25	0.29	0.29	0.09	0.09	0.01	XXX
99420		N	Health risk assessment test	0.00	0.24	0.25	NA	NA	0.01	XXX
99429		N	Unlisted preventive service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99441		N	Phone e/m by phys 5-10 min	0.25	0.12	0.12	0.09	0.08	0.01	XXX
99442		N	Phone e/m by phys 11-20 min	0.50	0.21	0.21	0.18	0.18	0.03	XXX
99443		N	Phone e/m by phys 21-30 min	0.75	0.30	0.29	0.27	0.26	0.04	XXX
99444		N	Online e/m by phys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99450		N	Basic life disability exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99455		R	Work related disability exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99456		R	Disability examination	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99460		A	Init nb em per day, hosp	1.17	NA	NA	0.44	0.37	0.06	XXX
99461		A	Init nb em per day, non-fac	1.26	1.22	1.08	0.46	0.44	0.06	XXX
99462		A	Sbsq nb em per day, hosp	0.62	NA	NA	0.23	0.20	0.03	XXX
99463		A	Same day nb discharge	1.50	NA	NA	0.70	0.58	0.08	XXX
99464		A	Attendance at delivery	1.50	NA	NA	0.50	0.43	0.08	XXX
99465		A	Nb resuscitation	2.93	NA	NA	1.07	1.01	0.15	XXX
99466		A	Ped crit care transport	4.79	NA	NA	1.77	1.52	0.24	XXX
99467		A	Ped crit care transport addl	2.40	NA	NA	0.95	0.77	0.12	ZZZ
99468		A	Neonate crit care, initial	18.46	NA	NA	6.98	5.22	0.93	XXX
99469		A	Neonate crit care, subsq	7.99	NA	NA	2.65	2.36	0.40	XXX
99471		A	Ped critical care, initial	15.98	NA	NA	5.30	4.76	0.80	XXX
99472		A	Ped critical care, subsq	7.99	NA	NA	2.75	2.39	0.40	XXX
99475		A	Ped crit care age 2-5, init	11.25	3.43	3.03	3.43	3.03	0.56	XXX
99476		A	Ped crit care age 2-5, subsq	6.75	2.06	1.82	2.06	1.82	0.34	XXX
99477		A	Init day hosp neonate care	7.00	NA	NA	2.32	2.15	0.28	XXX
99478		A	Ic, lbw inf < 1500 gm subsq	2.75	NA	NA	1.09	0.97	0.14	XXX
99479		A	Ic lbw inf 1500-2500 g subsq	2.50	NA	NA	0.99	0.79	0.13	XXX
99480		A	Ic inf pbw 2501-5000 g subsq	2.40	NA	NA	0.91	0.76	0.12	XXX
99499		C	Unlisted e&m service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99500		I	Home visit, prenatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99501		I	Home visit, postnatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99502		I	Home visit, nb care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99503		I	Home visit, resp therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99504		I	Home visit mech ventilator	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99505		I	Home visit, stoma care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99506		I	Home visit, im injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99507		I	Home visit, cath maintain	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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99509		I	Home visit day life activity	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99510		I	Home visit, sng/m/fam couns	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99511		I	Home visit, fecal/enema mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99512		I	Home visit for hemodialysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99600		I	Home visit nos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99601		I	Home infusion/visit, 2 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99602		I	Home infusion, each addtl hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99605		X	Mtms by pharm, np, 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99606		X	Mtms by pharm, est, 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99607		X	Mtms by pharm, addl 15 min	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4890		R	Repair/maint cont hemo equip	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9500		C	Tc99m sestamibi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9501		C	Technetium TC-99m teboroxime	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9502		C	Tc99m tetrofosmin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9503		C	Tc99m medronate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9504		C	Tc99m apcitide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9505		C	TL201 thallium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9507		C	In111 capromab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9508		C	I131 iodobenguate, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9509		C	Iodine I-123 sod iodide mil	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9510		C	Tc99m disofenin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9512		C	Tc99m pertechnetate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9516		C	Iodine I-123 sod iodide mic	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9517		C	I131 iodide cap, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9521		C	Tc99m exametazime	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9524		C	I131 serum albumin, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9526		C	Nitrogen N-13 ammonia	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9527		C	Iodine I-125 sodium iodide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9528		C	Iodine I-131 iodide cap, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9529		C	I131 iodide sol, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9530		C	I131 iodide sol, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9531		C	I131 max 100uCi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9532		C	I125 serum albumin, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9536		C	Tc99m depreotide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9537		C	Tc99m mebrofenin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9538		C	Tc99m pyrophosphate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9539		C	Tc99m pentetate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9540		C	Tc99m MAA	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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A9541		C	Tc99m sulfur colloid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9542		C	In111 ibritumomab, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9543		C	Y90 ibritumomab, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9544		C	I131 tositumomab, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9545		C	I131 tositumomab, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9546		C	Co57/58	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9547		C	In111 oxyquinoline	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9548		C	In111 pentetate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9550		C	Tc99m gluceptate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9551		C	Tc99m succimer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9552		C	F18 fdg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9553		C	Cr51 chromate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9554		C	I125 iothalamate, dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9555		C	Rb82 rubidium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9556		C	Ga67 gallium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9557		C	Tc99m bicisate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9558		C	Xe133 xenon 10mci	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9559		C	Co57 cyano	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9560		C	Tc99m labeled rbc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9561		C	Tc99m oxidronate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9562		C	Tc99m mertiatide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9563		C	P32 Na phosphate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9564		C	P32 chromic phosphate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9566		C	Tc99m fanolesomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9567		C	Technetium TC-99m aerosol	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9568		C	Technetium tc99m arcitumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9569		C	Technetium TC-99m auto WBC	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9570		C	Indium In-111 auto WBC	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9571		C	Indium IN-111 auto platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9572		C	Indium In-111 pentetreotide	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9580		C	Sodium fluoride F-18	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9600		C	Sr89 strontium	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9698		C	Non-rad contrast materialNOC	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A9699		C	Radiopharm rx agent noc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0008		X	Admin influenza virus vac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0009		X	Admin pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0010		X	Admin hepatitis b vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0027		X	Semen analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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G0101		A	CA screen;pelvic/breast exam	0.45	0.51	0.50	NA	NA	0.02	XXX
G0102		A	Prostate ca screening; dre	0.17	0.31	0.34	0.07	0.06	0.01	XXX
G0103		X	PSA screening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0104		A	CA screen;flexi sigmoidscope	0.96	2.44	2.47	0.65	0.62	0.06	000
G0105		A	Colorectal scrn; hi risk ind	3.69	5.90	6.26	1.83	1.82	0.24	000
G0105	53	A	Colorectal scrn; hi risk ind	0.96	2.44	2.47	0.65	0.62	0.05	000
G0106		A	Colon CA screen;barium enema	0.99	4.34	4.41	NA	NA	0.03	XXX
G0106	TC	A	Colon CA screen;barium enema	0.00	4.04	4.05	NA	NA	0.01	XXX
G0106	26	A	Colon CA screen;barium enema	0.99	0.30	0.36	0.30	0.36	0.02	XXX
G0108		A	Diab manage trn per indiv	0.00	0.62	0.64	NA	NA	0.01	XXX
G0109		A	Diab manage trn ind/group	0.00	0.32	0.35	NA	NA	0.01	XXX
G0117		T	Glaucoma scrn hgh risk direc	0.45	0.88	0.80	NA	NA	0.02	XXX
G0118		T	Glaucoma scrn hgh risk direc	0.17	0.89	0.71	NA	NA	0.01	XXX
G0120		A	Colon ca scrn; barium enema	0.99	4.34	4.41	NA	NA	0.03	XXX
G0120	TC	A	Colon ca scrn; barium enema	0.00	4.04	4.05	NA	NA	0.01	XXX
G0120	26	A	Colon ca scrn; barium enema	0.99	0.30	0.36	0.30	0.36	0.02	XXX
G0121		A	Colon ca scrn not hi rsk ind	3.69	5.90	6.26	1.83	1.82	0.25	000
G0121	53	A	Colon ca scrn not hi rsk ind	0.96	2.44	2.47	0.65	0.62	0.08	000
G0122		N	Colon ca scrn; barium enema	0.99	6.10	5.65	NA	NA	0.03	XXX
G0122	TC	N	Colon ca scrn; barium enema	0.00	5.74	5.30	NA	NA	0.01	XXX
G0122	26	N	Colon ca scrn; barium enema	0.99	0.36	0.35	0.36	0.35	0.02	XXX
G0123		X	Screen cerv/vag thin layer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0124		A	Screen c/v thin layer by MD	0.42	0.34	0.32	0.34	0.32	0.02	XXX
G0127		R	Trim nail(s)	0.17	0.40	0.36	0.04	0.05	0.01	000
G0128		R	CORF skilled nursing service	0.08	0.17	0.15	NA	NA	0.01	XXX
G0130		A	Single energy x-ray study	0.22	0.61	0.63	NA	NA	0.02	XXX
G0130	TC	A	Single energy x-ray study	0.00	0.53	0.56	NA	NA	0.01	XXX
G0130	26	A	Single energy x-ray study	0.22	0.08	0.07	0.08	0.07	0.01	XXX
G0141		A	Scr c/v cyto,autosys and md	0.42	0.34	0.32	0.34	0.32	0.02	XXX
G0143		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0144		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0145		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0147		X	Scr c/v cyto, automated sys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0148		X	Scr c/v cyto, autosys, rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0166		A	Extrnl counterpulse, per tx	0.07	3.31	3.95	NA	NA	0.01	XXX
G0168		A	Wound closure by adhesive	0.45	1.88	1.71	0.26	0.23	0.03	000
G0173		X	Linear acc stereo radsur com	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0175		X	OPPS Service,sched team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0176		X	OPPS/PHP;activity therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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G0177		X	OPPS/PHP; train & educ serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0179		A	MD recertification HHA PT	0.45	0.57	0.61	NA	NA	0.02	XXX
G0180		A	MD certification HHA patient	0.67	0.67	0.73	NA	NA	0.04	XXX
G0181		A	Home health care supervision	1.73	1.05	1.01	NA	NA	0.08	XXX
G0182		A	Hospice care supervision	1.73	1.06	1.06	NA	NA	0.08	XXX
G0186		C	Dstry eye lesn,fdr vssl tech	0.00	0.00	0.00	0.00	0.00	0.00	YYY
G0202		A	Screeningmammographydigital	0.70	2.80	2.84	NA	NA	0.04	XXX
G0202	TC	A	Screeningmammographydigital	0.00	2.56	2.60	NA	NA	0.01	XXX
G0202	26	A	Screeningmammographydigital	0.70	0.24	0.24	0.24	0.24	0.03	XXX
G0204		A	Diagnosticmammographydigital	0.87	3.40	3.35	NA	NA	0.05	XXX
G0204	TC	A	Diagnosticmammographydigital	0.00	3.10	3.05	NA	NA	0.01	XXX
G0204	26	A	Diagnosticmammographydigital	0.87	0.30	0.30	0.30	0.30	0.04	XXX
G0206		A	Diagnosticmammographydigital	0.70	2.67	2.63	NA	NA	0.04	XXX
G0206	TC	A	Diagnosticmammographydigital	0.00	2.43	2.39	NA	NA	0.01	XXX
G0206	26	A	Diagnosticmammographydigital	0.70	0.24	0.24	0.24	0.24	0.03	XXX
G0219		N	PET img wholbod melano nonco	0.00	0.00	0.00	NA	NA	0.00	XXX
G0219	TC	N	PET img wholbod melano nonco	0.00	0.00	0.00	NA	NA	0.00	XXX
G0219	26	N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0235		N	PET not otherwise specified	0.00	0.00	0.00	NA	NA	0.00	XXX
G0235	TC	N	PET not otherwise specified	0.00	0.00	0.00	NA	NA	0.00	XXX
G0235	26	N	PET not otherwise specified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0237		A	Therapeutic procd strg endur	0.00	0.20	0.26	NA	NA	0.01	XXX
G0238		A	Oth resp proc, indiv	0.00	0.21	0.28	NA	NA	0.01	XXX
G0239		A	Oth resp proc, group	0.00	0.26	0.30	NA	NA	0.01	XXX
G0245		R	Initial foot exam pt lops	0.88	0.97	0.88	0.40	0.35	0.05	XXX
G0246		R	Followup eval of foot pt lop	0.45	0.61	0.57	0.20	0.17	0.02	XXX
G0247		R	Routine footcare pt w lops	0.50	0.72	0.66	0.16	0.17	0.03	ZZZ
G0248		R	Demonstrate use home inr mon	0.00	2.77	3.84	NA	NA	0.01	XXX
G0249		R	Provide INR test mater/equip	0.00	2.68	3.34	NA	NA	0.01	XXX
G0250		R	MD INR test revie inter mgmt	0.18	0.06	0.08	NA	NA	0.01	XXX
G0251		E	Linear acc based stero radio	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0252		N	PET imaging initial dx	0.00	0.00	0.00	NA	NA	0.00	XXX
G0252	TC	N	PET imaging initial dx	0.00	0.00	0.00	NA	NA	0.00	XXX
G0252	26	N	PET imaging initial dx	1.50	0.00	0.60	0.00	0.60	0.04	XXX
G0255		N	Current percep threshold tst	0.00	0.00	0.00	NA	NA	0.00	XXX
G0255	TC	N	Current percep threshold tst	0.00	0.00	0.00	NA	NA	0.00	XXX

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G0255	26	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0257		E	Unsched dialysis ESRD pt hos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0259		E	Inject for sacroiliac joint	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0260		E	Inj for sacroiliac jt anesth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0268		A	Removal of impacted wax md	0.61	0.76	0.70	0.29	0.24	0.02	000
G0269		B	Occlusive device in vein art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0270		A	MNT subs tx for change dx	0.45	0.20	0.24	0.16	0.19	0.02	XXX
G0271		A	Group MNT 2 or more 30 mins	0.25	0.10	0.10	0.09	0.10	0.01	XXX
G0275		A	Renal angio, cardiac cath	0.25	NA	NA	0.08	0.12	0.01	ZZZ
G0278		A	Iliac art angio,cardiac cath	0.25	NA	NA	0.08	0.12	0.01	ZZZ
G0281		A	Elec stim unattend for press	0.18	0.17	0.14	NA	NA	0.01	XXX
G0282		N	Elect stim wound care not pd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0283		A	Elec stim other than wound	0.18	0.17	0.14	NA	NA	0.01	XXX
G0288		A	Recon, CTA for surg plan	0.00	0.82	2.80	NA	NA	0.01	XXX
G0289		A	Arthro, loose body + chondro	1.48	NA	NA	0.72	0.69	0.21	ZZZ
G0290		E	Drug-eluting stents, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0291		E	Drug-eluting stents,each add	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0293		E	Non-cov surg proc,clin trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0294		E	Non-cov proc, clinical trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0295		N	Electromagnetic therapy onc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0302		X	Pre-op service LVRS complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0303		X	Pre-op service LVRS 10-15dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0304		X	Pre-op service LVRS 1-9 dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0305		X	Post op service LVRS min 6	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0306		X	CBC/diffwbc w/o platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0307		X	CBC without platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0328		X	Fecal blood scrn immunoassay	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0329		A	Electromagnetic tx for ulcers	0.06	0.18	0.16	NA	NA	0.01	XXX
G0333		X	Dispense fee initial 30 day	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0337		X	Hospice evaluation preelecti	1.42	0.52	0.52	0.52	0.52	0.10	XXX
G0339		C	Robot lin-radsurg com, first	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0340		C	Robt lin-radsurg fractx 2-5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0341		A	Percutaneous islet celltrans	6.98	45.38	14.46	2.41	3.53	0.35	000
G0342		A	Laparoscopy islet cell trans	11.92	NA	NA	6.71	5.72	0.60	090
G0343		A	Laparotomy islet cell transp	19.85	NA	NA	11.34	9.65	0.99	090
G0364		A	Bone marrow aspirate &biopsy	0.16	0.16	0.16	0.08	0.07	0.01	ZZZ
G0365		A	Vessel mapping hemo access	0.25	5.14	4.99	NA	NA	0.03	XXX
G0365	TC	A	Vessel mapping hemo access	0.00	5.06	4.92	NA	NA	0.01	XXX
G0365	26	A	Vessel mapping hemo access	0.25	0.08	0.07	0.08	0.07	0.02	XXX

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G0372		A	MD service required for PMD	0.17	0.07	0.12	0.07	0.05	0.01	XXX
G0378		X	Hospital observation per hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0379		X	Direct refer hospital observ	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0389		A	Ultrasound exam AAA screen	0.58	2.07	2.35	NA	NA	0.03	XXX
G0389	TC	A	Ultrasound exam AAA screen	0.00	1.89	2.13	NA	NA	0.01	XXX
G0389	26	A	Ultrasound exam AAA screen	0.58	0.18	0.22	0.18	0.22	0.02	XXX
G0396		A	Alcohol/subs interv 15-30mn	0.65	0.27	0.22	0.22	0.18	0.03	XXX
G0397		A	Alcohol/subs interv >30 min	1.30	0.64	0.43	0.59	0.39	0.07	XXX
G0398		C	Home sleep test/type 2 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0398	TC	C	Home sleep test/type 2 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0398	26	C	Home sleep test/type 2 Porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0399		C	Home sleep test/type 3 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0399	TC	C	Home sleep test/type 3 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0399	26	C	Home sleep test/type 3 Porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0400		C	Home sleep test/type 4 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0400	TC	C	Home sleep test/type 4 Porta	0.00	0.00	0.00	NA	NA	0.00	XXX
G0400	26	C	Home sleep test/type 4 Porta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0402		A	Initial preventive exam	2.30	1.82	1.32	NA	NA	0.07	XXX
G0403		A	EKG for initial prevent exam	0.17	0.28	0.36	NA	NA	0.02	XXX
G0404		A	EKG tracing for initial prev	0.00	0.22	0.29	NA	NA	0.01	XXX
G0405		A	EKG interpret & report preve	0.17	0.06	0.07	0.06	0.05	0.01	XXX
G0406		A	Telhealth inpt consult 15min	0.76	NA	NA	0.28	0.26	0.04	XXX
G0407		A	Telheath inpt consult 25min	1.39	NA	NA	0.52	0.45	0.07	XXX
G0408		A	Telhealth inpt consult 35min	2.00	NA	NA	0.73	0.64	0.10	XXX
G0409		A	CORF related serv 15 mins ea	0.00	0.22	0.23	NA	NA	0.01	XXX
G0410		X	Grp psych partial hosp 45-50	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0411		X	Inter active grp psych parti	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0412		A	Open tx iliac spine uni/bil	10.45	NA	NA	7.66	7.06	0.52	090
G0413		A	Pelvic ring fracture uni/bil	15.73	NA	NA	10.75	10.00	0.79	090
G0414		A	Pelvic ring fx treat int fix	14.65	NA	NA	10.40	9.74	0.73	090
G0415		A	Open tx post pelvic fxcture	20.93	NA	NA	13.57	12.36	1.05	090
G0416		A	Sat biopsy prostate 1-20 spc	3.09	13.96	13.96	NA	NA	0.08	XXX
G0416	TC	A	Sat biopsy prostate 1-20 spc	0.00	12.14	12.14	NA	NA	0.01	XXX
G0416	26	A	Sat biopsy prostate 1-20 spc	3.09	1.82	1.82	1.82	1.82	0.07	XXX
G0417		A	Sat biopsy prostate 21-40	5.86	27.26	27.26	NA	NA	0.15	XXX
G0417	TC	A	Sat biopsy prostate 21-40	0.00	23.71	23.71	NA	NA	0.01	XXX
G0417	26	A	Sat biopsy prostate 21-40	5.86	3.55	3.55	3.55	3.55	0.14	XXX
G0418		A	Sat biopsy prostate 41-60	10.30	46.56	46.56	NA	NA	0.26	XXX
G0418	TC	A	Sat biopsy prostate 41-60	0.00	40.50	40.50	NA	NA	0.01	XXX

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G0418	26	A	Sat biopsy prostate 41-60	10.30	6.06	6.06	6.06	6.06	0.25	XXX
G0419		A	Sat biopsy prostate: >60	11.61	55.86	55.86	NA	NA	0.29	XXX
G0419	TC	A	Sat biopsy prostate: >60	0.00	48.60	48.60	NA	NA	0.01	XXX
G0419	26	A	Sat biopsy prostate: >60	11.61	7.26	7.26	7.26	7.26	0.28	XXX
G0420		A	Ed svc CKD ind per session	2.12	0.86	0.86	NA	NA	0.02	XXX
G0421		A	Ed svc CKD grp per session	0.50	0.20	0.20	NA	NA	0.01	XXX
G0422		A	Intens cardiac rehab w/exerc	0.60	0.74	0.75	0.74	0.75	0.01	XXX
G0423		A	Intens cardiac rehab no exer	0.60	0.74	0.75	0.74	0.75	0.01	XXX
G0424		A	Pulmonary rehab w exer	0.18	0.46	0.46	0.07	0.07	0.01	XXX
G0425		A	Inpt telehealth consult 30m	1.89	NA	NA	0.70	0.70	0.13	XXX
G0426		A	Inpt telehealth consult 50m	2.57	NA	NA	0.98	0.98	0.15	XXX
G0427		A	Inpt telehealth con 70/>m	3.79	NA	NA	1.43	1.43	0.20	XXX
G0430		X	Drug screen multi class	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0431		X	Drug screen single class	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G3001		X	Admin + supply, tositumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9001		X	MCCD, initial rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9002		X	MCCD,maintenance rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9003		X	MCCD, risk adj hi, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9004		X	MCCD, risk adj lo, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9005		X	MCCD, risk adj, maintenance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9006		X	MCCD, Home monitoring	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9007		X	MCCD, sch team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9008		X	Mccd,phys coor-care ovrsght	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9009		X	MCCD, risk adj, level 3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9010		X	MCCD, risk adj, level 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9011		X	MCCD, risk adj, level 5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9012		X	Other Specified Case Mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9013		N	ESRD demo bundle level I	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9014		N	ESRD demo bundle-level II	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9016		N	Demo-smoking cessation coun	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9017		X	Amantadine HCL 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9018		X	Zanamivir,inhalation pwd 10m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9019		X	Oseltamivir phosphate 75mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9020		X	Rimantadine HCL 100mg oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9033		X	Amantadine HCL oral brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9034		X	Zanamivir, inh pwdr, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9035		X	Oseltamivir phosp, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9036		X	Rimantadine HCL, brand	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9041		A	Low vision rehab occupationa	0.69	0.28	0.28	0.28	0.28	0.02	XXX

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G9042		A	Low vision rehab orient/mobi	0.25	0.25	0.25	0.25	0.25	0.01	XXX
G9043		A	Low vision lowvision therapi	0.25	0.25	0.25	0.25	0.25	0.01	XXX
G9044		A	Low vision rehabilate teache	0.24	0.19	0.19	0.19	0.19	0.01	XXX
G9140		X	Frontier extended stay demo	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9141		X	Influenza A H1N1,admin w cou	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9142		X	Influenza A H1N1, vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9143		X	Warfarin respon genetic test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
M0064		A	Visit for drug monitoring	0.37	0.89	0.79	0.06	0.08	0.01	XXX
P3001		A	Screening pap smear by phys	0.42	0.34	0.32	0.34	0.32	0.02	XXX
Q0035		A	Cardiokymography	0.17	0.26	0.32	NA	NA	0.02	XXX
Q0035	TC	A	Cardiokymography	0.00	0.21	0.27	NA	NA	0.01	XXX
Q0035	26	A	Cardiokymography	0.17	0.05	0.05	0.05	0.05	0.01	XXX
Q0091		A	Obtaining screen pap smear	0.37	0.74	0.74	0.14	0.12	0.02	XXX
Q0092		A	Set up port xray equipment	0.00	0.60	0.49	0.60	0.49	0.01	XXX
Q3001		C	Brachytherapy Radioelements	0.00	0.00	0.00	0.00	0.00	0.00	XXX
Q3014		X	Telehealth facility fee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0070		C	Transport portable x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0075		C	Transport port x-ray multipl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0076		B	Transport portable EKG	0.00	0.00	0.00	0.00	0.00	0.00	XXX
V5299		R	Hearing service	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM C: Codes with Interim RVUs

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Fully Implemented Non-Facility PE RVUs[2]	Year 2010 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2010 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
14301		A	Skin tissue rearrangement	12.65	14.34	14.34	9.96	9.96	1.53	090
14302		A	Skin tissue rearrange add-on	3.73	2.08	2.08	2.08	2.08	0.45	ZZZ
19340		A	Immediate breast prosthesis	13.78	NA	NA	11.45	5.19	0.89	090
21011		A	Exc face les sc < 2 cm	2.99	5.18	5.18	3.33	3.33	0.32	090
21012		A	Exc face les sc = 2 cm	4.45	NA	NA	4.12	4.12	0.52	090
21013		A	Exc face tum deep < 2 cm	5.42	7.18	7.18	4.69	4.69	0.59	090
21014		A	Exc face tum deep = 2 cm	7.13	NA	NA	6.09	6.09	0.82	090
21015		A	Resect face tum < 2 cm	9.89	NA	NA	7.95	5.50	0.76	090
21016		A	Resect face tum = 2 cm	15.26	NA	NA	10.90	10.90	2.07	090
21025		A	Excision of bone, lower jaw	10.03	12.65	11.69	9.37	8.39	1.02	090
21552		A	Exc neck les sc = 3 cm	6.49	NA	NA	4.74	4.74	0.91	090
21554		A	Exc neck tum deep = 5 cm	11.13	NA	NA	7.31	7.31	1.50	090
21555		A	Exc neck les sc < 3 cm	3.96	6.30	5.97	3.77	3.57	0.63	090
21556		A	Exc neck tum deep < 5 cm	7.66	NA	NA	5.78	4.66	0.76	090
21557		A	Resect neck tum < 5 cm	14.75	NA	NA	9.67	6.16	1.21	090
21558		A	Resect neck tum = 5 cm	21.58	NA	NA	12.92	12.92	2.93	090
21930		A	Exc back les sc < 3 cm	4.94	6.61	6.23	4.13	3.89	0.75	090
21931		A	Exc back les sc = 3 cm	6.88	NA	NA	4.82	4.82	1.01	090
21932		A	Exc back tum deep < 5 cm	9.82	NA	NA	6.95	6.95	1.50	090
21933		A	Exc back tum deep = 5 cm	11.13	NA	NA	7.31	7.31	1.71	090
21935		A	Resect back tum < 5 cm	15.72	NA	NA	9.95	9.41	2.72	090
21936		A	Resect back tum = 5 cm	22.55	NA	NA	13.14	13.14	3.30	090
22900		A	Exc back tum deep < 5 cm	8.32	NA	NA	5.68	4.13	0.92	090
22901		A	Exc back tum deep = 5 cm	10.11	NA	NA	6.36	6.36	1.51	090
22902		A	Exc abd les sc < 3 cm	4.42	6.41	6.41	4.14	4.14	0.51	090
22903		A	Exc abd les sc > 3 cm	6.39	NA	NA	4.63	4.63	0.86	090
22904		A	Resect abd tum < 5 cm	16.69	NA	NA	8.91	8.91	2.56	090
22905		A	Resect abd tum > 5 cm	21.58	NA	NA	11.62	11.62	3.30	090
23071		A	Exc shoulder les sc > 3 cm	5.91	NA	NA	4.52	4.52	0.86	090
23073		A	Exc shoulder tum deep > 5 cm	10.13	NA	NA	7.11	7.11	1.48	090
23075		A	Exc shoulder les sc < 3 cm	4.21	7.06	4.59	3.92	2.34	0.36	090
23076		A	Exc shoulder tum deep < 5 cm	7.41	NA	NA	5.88	5.63	1.14	090
23077		A	Resect shoulder tum < 5 cm	17.66	NA	NA	11.18	10.44	2.67	090
23078		A	Resect shoulder tum > 5 cm	22.55	NA	NA	11.98	11.98	3.45	090
23200		A	Resect clavicle tumor	22.71	NA	NA	15.21	10.03	1.82	090
23210		A	Resect scapula tumor	27.21	NA	NA	17.41	10.97	1.89	090
23220		A	Resect prox humerus tumor	30.21	NA	NA	18.64	12.16	2.20	090

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Fully Implemented Non-Facility PE RVUs[2]	Year 2010 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2010 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
23415		A	Release of shoulder ligament	9.23	NA	NA	7.98	7.47	1.28	090
24071		A	Exc arm/elbow les sc = 3 cm	5.70	NA	NA	4.44	4.44	0.82	090
24073		A	Ex arm/elbow tum deep > 5 cm	10.13	NA	NA	7.23	7.23	1.45	090
24075		A	Exc arm/elbow les sc < 3 cm	4.24	7.55	7.40	3.99	3.56	0.57	090
24076		A	Ex arm/elbow tum deep < 5 cm	7.41	NA	NA	6.03	5.13	0.92	090
24077		A	Resect arm/elbow tum < 5 cm	15.72	NA	NA	10.27	8.08	1.76	090
24079		A	Resect arm/elbow tum > 5 cm	20.61	NA	NA	11.26	11.26	3.15	090
24150		A	Resect distal humerus tumor	23.46	NA	NA	15.48	10.87	1.97	090
24152		A	Resect radius tumor	19.99	NA	NA	13.78	8.90	1.46	090
25071		A	Exc forearm les sc > 3 cm	5.91	NA	NA	4.74	4.74	0.83	090
25073		A	Exc forearm tum deep = 3 cm	7.13	NA	NA	6.20	6.20	0.96	090
25075		A	Exc forearm les sc < 3 cm	3.96	7.56	4.96	3.96	4.04	0.54	090
25076		A	Exc forearm tum deep < 3 cm	6.74	NA	NA	6.02	5.74	0.68	090
25077		A	Resect forearm/wrist tum<3cm	12.93	NA	NA	9.12	8.23	1.45	090
25078		A	Resect forearm/wrist tum=3cm	17.69	NA	NA	10.18	10.18	2.71	090
25116		A	Remove wrist/forearm lesion	7.56	NA	NA	7.41	7.98	0.94	090
25170		A	Resect radius/ulnar tumor	22.21	NA	NA	14.77	11.07	1.62	090
26111		A	Exc hand les sc > 1.5 cm	5.42	NA	NA	5.01	5.01	0.69	090
26113		A	Exc hand tum deep > 1.5 cm	7.13	NA	NA	6.61	6.61	0.89	090
26115		A	Exc hand les sc < 1.5 cm	3.96	8.07	10.11	4.36	4.46	0.51	090
26116		A	Exc hand tum deep < 1.5 cm	6.74	NA	NA	6.41	5.85	0.71	090
26117		A	Exc hand tum ra < 3 cm	10.13	NA	NA	8.60	7.16	1.13	090
26118		A	Exc hand tum ra > 3 cm	14.81	NA	NA	11.83	11.83	2.09	090
26250		A	Extensive hand surgery	15.21	NA	NA	11.43	7.50	1.08	090
26260		A	Resect prox finger tumor	11.16	NA	NA	8.80	6.56	1.01	090
26262		A	Resect distal finger tumor	8.29	NA	NA	7.39	5.62	0.81	090
26480		A	Transplant hand tendon	6.90	NA	NA	11.35	11.29	0.86	090
27043		A	Exc hip pelvis les sc > 3 cm	6.88	NA	NA	4.80	4.80	1.01	090
27045		A	Exc hip/pelv tum deep > 5 cm	11.13	NA	NA	7.42	7.42	1.63	090
27047		A	Exc hip/pelvis les sc < 3 cm	4.94	6.57	7.05	4.12	4.57	1.12	090
27048		A	Exc hip/pelv tum deep < 5 cm	8.85	NA	NA	6.34	5.22	0.95	090
27049		A	Resect hip/pelv tum < 5 cm	21.55	NA	NA	12.40	9.56	2.22	090
27059		A	Resect hip/pelv tum > 5 cm	29.35	NA	NA	15.95	15.95	4.17	090
27075		A	Resect hip tumor	32.71	NA	NA	19.16	18.45	5.26	090
27076		A	Resect hip tum incl acetabul	40.21	NA	NA	22.86	16.14	3.46	090
27077		A	Resect hip tum w/innom bone	45.21	NA	NA	26.15	22.51	6.08	090
27078		A	Rsect hip tum incl femur	32.21	NA	NA	19.77	12.21	2.09	090
27327		A	Exc thigh/knee les sc < 3 cm	3.96	7.19	6.42	3.83	3.76	0.67	090
27328		A	Exc thigh/knee tum deep <5cm	8.85	NA	NA	6.52	4.87	0.83	090

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27329		A	Resect thigh/knee tum < 5 cm	15.72	NA	NA	10.37	9.38	2.30	090
27337		A	Exc thigh/knee les sc > 3 cm	5.91	NA	NA	4.55	4.55	0.86	090
27339		A	Exc thigh/knee tum deep >5cm	11.13	NA	NA	7.63	7.63	1.63	090
27364		A	Resect thigh/knee tum >5 cm	24.49	NA	NA	14.54	14.54	3.56	090
27365		A	Resect femur/knee tumor	32 21	NA	NA	19.78	13.45	2.57	090
27615		A	Resect leg/ankle tum < 5 cm	15 72	NA	NA	10.32	8.67	1.87	090
27616		A	Resect leg/ankle tum > 5 cm	19.63	NA	NA	12.32	12.32	2.81	090
27618		A	Exc leg/ankle tum < 3 cm	3.96	7.04	6.62	3.76	3.93	0.70	090
27619		A	Exc leg/ankle tum deep <5 cm	6.91	NA	NA	5.29	5.51	1.08	090
27632		A	Exc leg/ankle les sc > 3 cm	5.91	NA	NA	4.47	4.47	0.80	090
27634		A	Exc leg/ankle tum deep >5 cm	10.13	NA	NA	6.81	6.81	1.28	090
27645		A	Resect tibia tumor	27 21	NA	NA	17.41	12.04	2.12	090
27646		A	Resect fibula tumor	23 21	NA	NA	15.45	10.59	1.90	090
27647		A	Resect talus/calcaneus tum	20.26	NA	NA	8.40	7.18	0.93	090
28039		A	Exc foot/toe tum sc > 1.5 cm	5.42	7.03	7.03	3.38	3.38	0.40	090
28041		A	Exc foot/toe tum deep >1.5cm	7.13	NA	NA	4.43	4.43	0.53	090
28043		A	Exc foot/toe tum sc < 1.5 cm	3.96	6.33	5.00	2.95	2.89	0.27	090
28045		A	Exc foot/toe tum deep <1.5cm	5.45	7.50	6.86	3.81	3.50	0.36	090
28046		A	Resect foot/toe tumor < 3 cm	12.38	NA	NA	6.94	6.29	1.03	090
28047		A	Resect foot/toe tumor > 3 cm	17.45	NA	NA	7.06	7.06	0.95	090
28120		A	Part removal of ankle/heel	8.27	10.23	8.51	5.86	4.59	0.56	090
28122		A	Partial removal of foot bone	7.72	9.01	8.35	5.15	5.04	0.58	090
28171		A	Resect tarsal tumor	16.41	NA	NA	6.35	5.59	0.54	090
28173		A	Resect metatarsal tumor	14.16	NA	NA	6.49	5.28	0.72	090
28175		A	Resect phalanx of toe tumor	8.29	NA	NA	4.83	3.98	0.43	090
28725		A	Fusion of foot bones	12.18	NA	NA	7.88	7.50	1.33	090
28730		A	Fusion of foot bones	12.42	NA	NA	9.00	8.40	1.36	090
29581		A	Apply multlay comprs lwr leg	0.60	1.74	1.74	0.23	0.23	0.06	000
31626		A	Bronchoscopy w/markers	4.16	7.33	7.33	1.46	1.46	0.23	000
31627		A	Navigational bronchoscopy	2.00	30.18	30.18	0.73	0.73	0.11	ZZZ
32552		A	Remove lung catheter	2.53	2.06	2.06	1.49	1.49	0.42	010
32553		A	Ins mark thor for rt perq	3.80	11.67	11.67	1.29	1.29	0.64	000
32560		A	Treat pleurodesis w/agent	1.54	4.48	5.23	0.48	0.62	0.28	000
32561		A	Lyse chest fibrin init day	1.39	1.04	1.04	0.43	0.43	0.18	000
32562		A	Lyse chest fibrin subq day	1.24	0.92	0.92	0.39	0.39	0.16	000
33782		A	Nikaidoh proc	60.08	NA	NA	20.65	20.65	10.19	090
33783		A	Nikaidoh proc w/ostia implt	65.08	NA	NA	22.16	22.16	11.04	090
33981		C	Replace vad pump ext	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33982		C	Replace vad intra w/o bp	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Fully Implemented Non-Facility PE RVUs[2]	Year 2010 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2010 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
33983		C	Replace vad intra w/bp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36147		A	Access av dial grft for eval	3.72	17.20	17.20	1.20	1.20	0.36	XXX
36148		A	Access av dial grft for proc	1.00	5.60	5.60	0.31	0.31	0.10	ZZZ
36825		A	Artery-vein autograft	15.13	NA	NA	6.80	5.20	1.61	090
37761		A	Ligate leg veins open	9.13	NA	NA	5.37	5.37	1.41	090
42415		A	Excise parotid gland/lesion	18.12	NA	NA	11.42	10.15	1.76	090
42420		A	Excise parotid gland/lesion	21.00	NA	NA	12.80	11.36	2.04	090
42440		A	Excise submaxillary gland	7.13	NA	NA	5.26	4.71	0.69	090
43281		A	Lap paraesophag hern repair	26.60	NA	NA	12.03	12.03	4.08	090
43282		A	Lap paraesoph her rpr w/mesh	30.10	NA	NA	13.32	13.32	4.62	090
43775		A	Lap sleeve gastrectomy	21.56	NA	NA	10.99	10.99	3.31	090
45171		A	Exc rect tum transanal part	8.13	NA	NA	6.90	6.90	1.06	090
45172		A	Exc rect tum transanal full	12.13	NA	NA	8.37	8.37	1.61	090
46707		A	Repair anorectal fist w/plug	6.39	NA	NA	5.27	5.27	0.65	090
49411		A	Ins mark abd/pel for rt perq	3.82	9.91	9.91	1.42	1.42	0.26	000
49507		A	Prp i/hern init block >5 yr	10.05	NA	NA	5.79	4.95	1.52	090
49521		A	Rerepair ing hernia, blocked	12.44	NA	NA	6.57	5.63	1.89	090
49587		A	Rpr umbil hern, block > 5 yr	8.04	NA	NA	4.98	4.25	1.21	090
51727	26	A	Cystometrogram w/up	2.11	0.75	0.75	0.75	0.75	0.14	000
51728	26	A	Cystometrogram w/vp	2.11	0.73	0.73	0.73	0.73	0.12	000
51729	26	A	Cystometrogram w/vp&up	2.11	0.74	0.74	0.74	0.74	0.13	000
52341		A	Cysto w/ureter stricture tx	5.35	NA	NA	2.22	2.66	0.38	000
52342		A	Cysto w/up stricture tx	5.85	NA	NA	2.38	2.86	0.41	000
52343		A	Cysto w/renal stricture tx	6.55	NA	NA	2.61	3.14	0.46	000
52344		A	Cysto/uretero, stricture tx	7.05	NA	NA	2.90	3.47	0.50	000
52345		A	Cysto/uretero w/up stricture	7.55	NA	NA	3.07	3.67	0.53	000
52346		A	Cystouretero w/renal strict	8.58	NA	NA	3.40	4.08	0.60	000
52400		A	Cystouretero w/congen repr	8.69	NA	NA	2.81	4.29	0.61	090
52500		A	Revision of bladder neck	8.14	NA	NA	4.49	5.24	0.56	090
52640		A	Relieve bladder contracture	4.79	NA	NA	2.81	3.39	0.33	090
53445		A	Insert uro/ves nck sphincter	15.39	NA	NA	7.43	8.76	1.07	090
53855		A	Insert prost urethral stent	1.64	16.31	16.31	0.54	0.54	0.11	000
54410		A	Remove/replace penis prosth	15.18	NA	NA	7.22	8.49	1.06	090
54530		A	Removal of testis	8.46	NA	NA	4.63	5.39	0.62	090
55873		A	Cryoablate prostate	13.60	147.06	45.92	6.30	10.14	1.46	090
57287		A	Revise/remove sling repair	11.15	NA	NA	6.33	6.69	1.04	090
57426		A	Revise prosth vag graft lap	14.30	NA	NA	7.61	7.61	1.74	090
62263		A	Epidural lysis mult sessions	6.54	12.48	10.60	4.37	3.37	0.37	010
62350		A	Implant spinal canal cath	6.05	NA	NA	4.07	3.39	0.75	010

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Fully Implemented Non-Facility PE RVUs[2]	Year 2010 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2010 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
63650		A	Implant neuroelectrodes	7.20	NA	NA	4.29	3.25	0.46	010
63661		A	Remove spine eltrd perq aray	5.08	9.73	9.73	3.19	3.19	0.01	010
63662		A	Remove spine eltrd plate	11.00	NA	NA	6.94	6.94	1.10	090
63663		A	Revise spine eltrd perq aray	7.75	13.43	13.43	4.27	4.27	0.78	010
63664		A	Revise spine eltrd plate	11.52	NA	NA	7.15	7.15	1.15	090
63685		A	Insrt/redo spine n generator	6.05	NA	NA	4.13	3.51	0.79	010
64490		A	Inj paravert f jnt c/t 1 lev	1.82	2.57	2.57	1.02	1.02	0.14	000
64491		A	Inj paravert f jnt c/t 2 lev	1.16	0.98	0.98	0.46	0.46	0.09	ZZZ
64492		A	Inj paravert f jnt c/t 3 lev	1.16	1.01	1.01	0.49	0.49	0.09	ZZZ
64493		A	Inj paravert f jnt l/s 1 lev	1.52	2.47	2.47	0.90	0.90	0.11	000
64494		A	Inj paravert f jnt l/s 2 lev	1.00	0.93	0.93	0.39	0.39	0.07	ZZZ
64495		A	Inj paravert f jnt l/s 3 lev	1.00	0.96	0.96	0.42	0.42	0.07	ZZZ
64708		A	Revise arm/leg nerve	6.36	NA	NA	5.98	5.33	0.81	090
64831		A	Repair of digit nerve	9.16	NA	NA	8.04	7.28	1.17	090
65285		A	Repair of eye wound	14.71	NA	NA	12.18	9.93	1.85	090
69100		A	Biopsy of external ear	0.81	1.68	1.80	0.48	0.43	0.08	000
74261	26	A	Ct colonography, w/o dye	2.28	0.69	0.69	0.69	0.69	0.09	XXX
74262	26	A	Ct colonography, w/dye	2.50	0.76	0.76	0.76	0.76	0.10	XXX
74263	26	N	Ct colonography, screen	2.28	0.83	0.83	0.83	0.83	0.09	XXX
75565	26	A	Card mri vel flw map add-on	0.25	0.09	0.09	0.09	0.09	0.01	XXX
75571	26	A	Ct hrt w/o dye w/ca test	0.58	0.18	0.18	0.18	0.18	0.01	XXX
75572	26	A	Ct hrt w/3d image	1.75	0.57	0.57	0.57	0.57	0.04	XXX
75573	26	A	Ct hrt w/3d image, congen	2.55	0.77	0.77	0.77	0.77	0.06	XXX
75574	26	A	Ct angio hrt w/3d image	2.40	0.77	0.77	0.77	0.77	0.05	XXX
75791	26	A	Av dialysis shunt imaging	1.71	0.53	0.53	0.53	0.53	0.07	XXX
76536	26	A	Us exam of head and neck	0.56	0.18	0.19	0.18	0.19	0.02	XXX
77338	26	A	Design mlc device for imrt	4.29	1.81	1.81	1.81	1.81	0.14	XXX
78451	26	A	Ht muscle image spect, sing	1.38	0.43	0.43	0.43	0.43	0.04	XXX
78452	26	A	Ht muscle image spect, mult	1.62	0.52	0.52	0.52	0.52	0.05	XXX
78453	26	A	Ht muscle image,planar,sing	1.00	0.31	0.31	0.31	0.31	0.03	XXX
78454	26	A	Ht musc image, planar, mult	1.34	0.40	0.40	0.40	0.40	0.04	XXX
88387	26	A	Tiss exam molecular study	0.62	0.24	0.24	0.24	0.24	0.01	XXX
88388	26	A	Tiss ex molecul study add-on	0.45	0.08	0.08	0.08	0.08	0.01	XXX
92526		A	Oral function therapy	1.34	0.65	1.39	0.51	0.27	0.02	XXX
92540	26	A	Basic vestibular evaluation	1.50	0.64	0.64	0.64	0.64	0.03	XXX
92550		A	Tympanometry & reflex thresh	0.35	0.21	0.21	NA	NA	0.01	XXX
92570		A	Acoustic immittance testing	0.55	0.30	0.30	0.25	0.25	0.02	XXX
92597		A	Oral speech device eval	1.26	0.67	1.61	0.60	0.41	0.03	XXX
92610		A	Evaluate swallowing function	1.30	0.79	1.79	0.57	1.73	0.01	XXX

[1] CPT codes and descriptors only are copyright 2009 American Medical Association All Rights Reserved Applicable FARS/DFARS apply

[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942 The required reduction will only be reflected in the files used for Medicare payment

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Fully Implemented Non-Facility PE RVUs[2]	Year 2010 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2010 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
92611		A	Motion fluoroscopy/swallow	1.34	0.97	1.98	NA	NA	0.01	XXX
93701		A	Bioimpedance, cv analysis	0.00	0.55	0.71	NA	NA	0.02	XXX
93750		A	Interrogation vad, in person	0.92	0.48	0.48	0.30	0.30	0.05	XXX
94011		A	Up to 2 yrs old, spirometry	2.00	0.62	0.62	0.62	0.62	0.05	XXX
94012		A	= 2 yrs, spiromtry w/dilator	3.10	0.94	0.94	0.94	0.94	0.08	XXX
94013		A	= 2 yrs, lung volumes	0.66	0.18	0.18	0.18	0.18	0.03	XXX
95905	26	A	Motor/sens nrve conduct test	0.05	0.02	0.02	0.02	0.02	0.01	XXX
96570		A	Photodynmc tx, 30 min add-on	1.10	0.37	0.40	0.37	0.40	0.13	ZZZ
96571		A	Photodynamic tx, addl 15 min	0.55	0.15	0.18	0.15	0.18	0.03	ZZZ
99358		B	Prolong service w/o contact	2.10	0.80	0.77	0.80	0.77	0.11	XXX
99359		B	Prolong serv w/o contact add	1.00	0.40	0.38	0.40	0.38	0.05	ZZZ

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[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

[3] Work RVUs reflect increases for 10 and 90 day global period codes as a result of the elimination of the consultation codes

[4] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment

ADDENDUM D: 2010 Geographic Adjustment Factors (GAFs)

Contractor	Locality	Locality name	2010 GAF **
00831	01	Alaska	1.288***
01102	06	San Mateo, CA	1.204
01102	05	San Francisco, CA	1.201
13202	01	Manhattan, NY	1.164
13202	02	NYC Suburbs/Long I., NY	1.162
01102	09	Santa Clara, CA	1.148
12402	01	Northern NJ	1.134
14202	01	Metropolitan Boston	1.134
01102	07	Oakland/Berkley, CA	1.131
13292	04	Queens, NY	1.130
01192	26	Anaheim/Santa Ana, CA	1.128
12202	01	DC + MD/VA Suburbs	1.121
01192	17	Ventura, CA	1.121
09102	04	Miami, FL	1.114
01192	18	Los Angeles, CA	1.112
01102	03	Marin/Napa/Solano, CA	1.112
13102	00	Connecticut	1.100
00952	16	Chicago, IL	1.085
12402	99	Rest of New Jersey	1.082
12502	01	Metropolitan Philadelphia, PA	1.075
00953	01	Detroit, MI	1.072
00952	15	Suburban Chicago, IL	1.063
01202	01	Hawaii/Guam	1.056
09102	03	Fort Lauderdale, FL	1.050
14402	01	Rhode Island	1.045
14202	99	Rest of Massachusetts	1.041
12302	01	Baltimore/Surr. Cntys, MD	1.035
13202	03	Poughkpsie/N NYC Suburbs, NY	1.034
00836	02	Seattle (King Cnty), WA	1.033
01302	00	Nevada	1.016
04402	18	Houston, TX	1.016
12102	01	Delaware	1.014
01102	99	Rest of California*	1.012
01192	99	Rest of California*	1.012
00528	01	New Orleans, LA	1.010
04402	11	Dallas, TX	1.010
10202	01	Atlanta, GA	1.005
00952	12	East St. Louis, IL	0.989
09202	50	Virgin Islands	0.989
00835	01	Portland, OR	0.987
04402	31	Austin, TX	0.987
09102	99	Rest of Florida	0.987
14302	40	New Hampshire	0.986
04402	15	Galveston, TX	0.986
04402	09	Brazoria, TX	0.985
12302	99	Rest of Maryland	0.984
04402	28	Fort Worth, TX	0.982
14102	03	Southern Maine	0.980
05302	02	Metropolitan Kansas City, MO	0.978
04102	01	Colorado	0.975
00883	00	Ohio	0.973
00836	99	Rest of Washington	0.970
05302	01	Metropolitan St Louis, MO	0.969
00953	99	Rest of Michigan	0.968
03102	00	Arizona	0.968
12502	99	Rest of Pennsylvania	0.966
00954	00	Minnesota	0.959
14502	50	Vermont	0.956
00904	00	Virginia	0.952
04402	20	Beaumont, TX	0.950
03502	09	Utah	0.948
00952	99	Rest of Illinois	0.943
13282	99	Rest of New York	0.941
04202	05	New Mexico	0.941
00630	00	Indiana	0.941
05535	00	North Carolina	0.938
00951	00	Wisconsin	0.936
04402	99	Rest of Texas	0.933
10202	99	Rest of Georgia	0.931
00835	99	Rest of Oregon	0.930
00528	99	Rest of Louisiana	0.927
10302	35	Tennessee	0.924
00880	01	South Carolina	0.924
00884	16	West Virginia	0.924
05202	00	Kansas	0.915
05130	00	Idaho	0.914
14102	99	Rest of Maine	0.913
00660	00	Kentucky	0.909
00512	00	Mississippi	0.907
10102	00	Alabama	0.907
03602	21	Wyoming	0.904
05102	00	Iowa	0.903
04302	00	Oklahoma	0.901
05402	00	Nebraska	0.901
05302	99	Rest of Missouri	0.895
03202	01	Montana	0.894
00520	13	Arkansas	0.891
03402	02	South Dakota	0.888
03302	01	North Dakota	0.880
09202	20	Puerto Rico	0.787

GAF equation: (0.52466 * work GPCI) + (0.43669 * pe GPCI)+(0.03865 * mp GPCI).

* Indicates multiple contractors.

**GAF values do not reflect the 1.000 floor on physician work GPCI established by the MIPPA.

***GAF value for Alaska reflects 1.500 floor on physician work GPCI established by the MIPPA.

ADDENDUM E: 2010 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality

Contractor	Locality	Locality name	Work** GPCI	PE GPCI	MP GPCI
10102	00	Alabama	0.982	0.853	0.496
00831	01	Alaska	1.500***	1.090	0.646
03102	00	Arizona	0.988	0.957	0.822
00520	13	Arkansas	0.961	0.846	0.446
01192	26	Anaheim/Santa Ana, CA	1.034	1.269	0.811
01192	18	Los Angeles, CA	1.041	1.225	0.804
01102	03	Marin/Napa/Solano, CA	1.034	1.265	0.432
01102	07	Oakland/Berkley, CA	1.053	1.286	0.425
01102	05	San Francisco, CA	1.059	1.441	0.414
01102	06	San Mateo, CA	1.072	1.433	0.394
01102	09	Santa Clara, CA	1.083	1.294	0.377
01192	17	Ventura, CA	1.027	1.265	0.766
01102	99	Rest of California*	1.007	1.058	0.549
01192	99	Rest of California*	1.007	1.058	0.549
04102	01	Colorado	0.986	0.992	0.641
13102	00	Connecticut	1.038	1.185	0.980
12202	01	DC + MD/VA Suburbs	1.047	1.218	1.032
12102	01	Delaware	1.011	1.046	0.678
09102	03	Fort Lauderdale, FL	0.989	1.018	2.250
09102	04	Miami, FL	1.000	1.069	3.167
09102	99	Rest of Florida	0.973	0.939	1.724
10202	01	Atlanta, GA	1.009	1.014	0.836
10202	99	Rest of Georgia	0.979	0.883	0.829
01202	01	Hawaii/Guam	0.998	1.161	0.665
05130	00	Idaho	0.967	0.883	0.546
00952	16	Chicago, IL	1.025	1.080	1.940
00952	12	East St Louis, IL	0.989	0.919	1.793
00952	15	Suburban Chicago, IL	1.017	1.068	1.629
00952	99	Rest of Illinois	0.975	0.880	1.219
00630	00	Indiana	0.986	0.918	0.599
05102	00	Iowa	0.965	0.870	0.434
05202	00	Kansas	0.969	0.882	0.557
00660	00	Kentucky	0.969	0.860	0.652
00528	01	New Orleans, LA	0.986	1.044	0.956
00528	99	Rest of Louisiana	0.970	0.878	0.892
14102	03	Southern Maine	0.980	1.025	0.492
14102	99	Rest of Maine	0.962	0.893	0.492
12302	01	Baltimore/Surr. Cntys, MD	1.012	1.057	1.086
12302	99	Rest of Maryland	0.994	0.982	0.874
14202	01	Metropolitan Boston	1.029	1.291	0.764
14202	99	Rest of Massachusetts	1.007	1.106	0.764
00953	01	Detroit, MI	1.036	1.040	1.906
00953	99	Rest of Michigan	0.998	0.923	1.083
00954	00	Minnesota	0.992	0.983	0.245
00512	00	Mississippi	0.959	0.854	0.808
05302	02	Metropolitan Kansas City, MO	0.990	0.945	1.188
05302	01	Metropolitan St Louis, MO	0.993	0.931	1.075
05302	99	Rest of Missouri	0.949	0.821	0.997
03202	01	Montana	0.950	0.847	0.673
05402	00	Nebraska	0.959	0.890	0.245
01302	00	Nevada	1.002	1.026	1.083
14302	40	New Hampshire	0.982	1.039	0.462
12402	01	Northern NJ	1.057	1.228	1.116
12402	99	Rest of New Jersey	1.042	1.126	1.116
04202	05	New Mexico	0.973	0.890	1.096
13202	01	Manhattan, NY	1.064	1.298	1.010
13202	02	NYC Suburbs/Long I., NY	1.051	1.289	1.235
13202	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.077	0.822
13292	04	Queens, NY	1.032	1.239	1.220
13282	99	Rest of New York	0.997	0.921	0.425
05535	00	North Carolina	0.972	0.925	0.634
03302	01	North Dakota	0.947	0.844	0.387
00883	00	Ohio	0.993	0.927	1.232
04302	00	Oklahoma	0.964	0.850	0.627
00835	01	Portland, OR	1.002	1.015	0.472
00835	99	Rest of Oregon	0.968	0.927	0.472
12502	01	Metropolitan Philadelphia, PA	1.016	1.097	1.617
12502	99	Rest of Pennsylvania	0.993	0.925	1.081
09202	20	Puerto Rico	0.904	0.694	0.250
14402	01	Rhode Island	1.013	1.088	0.996
00880	01	South Carolina	0.975	0.906	0.446
03402	02	South Dakota	0.942	0.864	0.420
10302	35	Tennessee	0.978	0.889	0.608
04402	31	Austin, TX	0.992	0.984	0.969
04402	20	Beaumont, TX	0.984	0.875	1.346
04402	09	Brazoria, TX	1.019	0.922	1.223
04402	11	Dallas, TX	1.009	1.001	1.110
04402	28	Fort Worth, TX	0.998	0.953	1.110
04402	15	Galveston, TX	0.991	0.959	1.223
04402	18	Houston, TX	1.016	0.986	1.345
04402	99	Rest of Texas	0.968	0.879	1.065
03502	09	Utah	0.977	0.907	1.026
14502	50	Vermont	0.968	0.983	0.489
00904	00	Virginia	0.982	0.942	0.657
09202	50	Virgin Islands	0.997	0.978	1.009
00836	02	Seattle (King Cnty), WA	1.014	1.085	0.706
00836	99	Rest of Washington	0.987	0.974	0.693
00884	16	West Virginia	0.973	0.827	1.353
00951	00	Wisconsin	0.988	0.921	0.409
03602	21	Wyoming	0.956	0.842	0.889

* Indicates multiple contractors.

** CY 2010 work GPCI does not reflect the 1.000 floor established by the MIPPA which expires January 1, 2010.

***CY 2010 work GPCI reflects 1.500 floor in Alaska established by the MIPPA.

ADDENDUM F: CY 2010 ESRD Wage Index for Nonurban Areas Based on CBSA Labor Market Areas

CBSA Code	Nonurban Area	Wage Index
1	Alabama	0.7750
2	Alaska	1.2343
3	Arizona	0.9297
4	Arkansas	0.7755
5	California	1.2747
6	Colorado	1.0502
7	Connecticut	1.1733
8	Delaware	1.0482
10	Florida	0.9061
11	Georgia	0.8063
12	Hawaii	1.1755
13	Idaho	0.8179
14	Illinois	0.8792
15	Indiana	0.9021
16	Iowa	0.9122
17	Kansas	0.8639
18	Kentucky	0.8264
19	Louisiana	0.8050
20	Maine	0.9074
21	Maryland	0.9658
22	Massachusetts	1.2375
23	Michigan	0.9285
24	Minnesota	0.9689
25	Mississippi	0.8079
26	Missouri	0.8114
27	Montana	0.8884
28	Nebraska	0.9208
29	Nevada	1.0233
30	New Hampshire	1.0532
31	New Jersey[1]	------
32	New Mexico	0.9454
33	New York	0.8746
34	North Carolina	0.9028
35	North Dakota	0.8264
36	Ohio	0.8997
37	Oklahoma	0.8096
38	Oregon	1.0827
39	Pennsylvania	0.8786
40	Puerto Rico	0.6875
41	Rhode Island[1]	------
42	South Carolina	0.8879
43	South Dakota	0.9001
44	Tennessee	0.8259
45	Texas	0.8207
46	Utah	0.8846
47	Vermont	1.0327
48	Virgin Islands	0.7844
49	Virginia	0.8323
50	Washington	1.0814
51	West Virginia	0.7823
52	Wisconsin	0.9738
53	Wyoming	1.0086

[1] All counties within the State are classified as urban

ADDENDUM G: CY 2010 ESRD Wage Index for Urban Areas Based on CBSA Labor Market Areas

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8405
10380	Aguadilla-Isabela-San Sebastian, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.6875
10420	Akron, OH Portage County, OH Summit County, OH	0.9361
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.9413
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.9284
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9942
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8475
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	1.0166
11020	Altoona, PA Blair County, PA	0.9375
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.9191
11180	Ames, IA Story County, IA	1.0041
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2707
11300	Anderson, IN Madison County, IN	0.9575
11340	Anderson, SC Anderson County, SC	0.9554
11460	Ann Arbor, MI Washtenaw County, MI	1.0887
11500	Anniston-Oxford, AL Calhoun County, AL	0.8084
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9825
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC	0.9580

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Madison County, NC	
12020	Athens-Clarke County, GA	1.0040
	Clarke County, GA	
	Madison County, GA	
	Oconee County, GA	
	Oglethorpe County, GA	
12060	Atlanta-Sandy Springs-Marietta, GA	1.0145
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	
12100	Atlantic City-Hammonton, NJ	1.2221
	Atlantic County, NJ	
12220	Auburn-Opelika, AL	0.8608
	Lee County, AL	
12260	Augusta-Richmond County, GA-SC	0.9952
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	
12420	Austin-Round Rock, TX	1.0068
	Bastrop County, TX	
	Caldwell County, TX	
	Hays County, TX	
	Travis County, TX	
	Williamson County, TX	
12540	Bakersfield, CA	1.1880
	Kern County, CA	
12580	Baltimore-Towson, MD	1.0604
	Anne Arundel County, MD	
	Baltimore County, MD	
	Carroll County, MD	
	Harford County, MD	
	Howard County, MD	
	Queen Anne's County, MD	
	Baltimore City, MD	
12620	Bangor, ME	1.0740
	Penobscot County, ME	
12700	Barnstable Town, MA	1.3347
	Barnstable County, MA	
12940	Baton Rouge, LA	0.8652
	Ascension Parish, LA	
	East Baton Rouge Parish, LA	
	East Feliciana Parish, LA	
	Iberville Parish, LA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Livingston Parish, LA	
	Pointe Coupee Parish, LA	
	St. Helena Parish, LA	
	West Baton Rouge Parish, LA	
	West Feliciana Parish, LA	
12980	Battle Creek, MI	1.0577
	Calhoun County, MI	
13020	Bay City, MI	0.9802
	Bay County, MI	
13140	Beaumont-Port Arthur, TX	0.8867
	Hardin County, TX	
	Jefferson County, TX	
	Orange County, TX	
13380	Bellingham, WA	1.2053
	Whatcom County, WA	
13460	Bend, OR	1.2107
	Deschutes County, OR	
13644	Bethesda-Frederick-Gaithersburg, MD	1.0893
	Frederick County, MD	
	Montgomery County, MD	
13740	Billings, MT	0.9288
	Carbon County, MT	
	Yellowstone County, MT	
13780	Binghamton, NY	0.9287
	Broome County, NY	
	Tioga County, NY	
13820	Birmingham-Hoover, AL	0.9048
	Bibb County, AL	
	Blount County, AL	
	Chilton County, AL	
	Jefferson County, AL	
	St. Clair County, AL	
	Shelby County, AL	
	Walker County, AL	
13900	Bismarck, ND	0.8078
	Burleigh County, ND	
	Morton County, ND	
13980	Blacksburg-Christiansburg-Radford, VA	0.8879
	Giles County, VA	
	Montgomery County, VA	
	Pulaski County, VA	
	Radford City, VA	
14020	Bloomington, IN	0.9565
	Greene County, IN	
	Monroe County, IN	
	Owen County, IN	
14060	Bloomington-Normal, IL	0.9919
	McLean County, IL	
14260	Boise City-Nampa, ID	0.9856
	Ada County, ID	
	Boise County, ID	
	Canyon County, ID	
	Gem County, ID	
	Owyhee County, ID	
14484	Boston-Quincy, MA	1.2890
	Norfolk County, MA	
	Plymouth County, MA	
	Suffolk County, MA	
14500	Boulder, CO	1.0859
	Boulder County, CO	
14540	Bowling Green, KY	0.8958
	Edmonson County, KY	
	Warren County, KY	
14600	Bradenton-Sarasota-Venice, FL	1.0297
	Manatee County, FL	
	Sarasota County, FL	
14740	Bremerton-Silverdale, WA	1.1376
	Kitsap County, WA	
14860	Bridgeport-Stamford-Norwalk, CT	1.3531
	Fairfield County, CT	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9541
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9708
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	1.0302
15500	Burlington, NC Alamance County, NC	0.9254
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	1.0689
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1929
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0973
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.9322
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9600
16180	Carson City, NV Carson City, NV	1.1150
16020	Cape Girardeau County, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.9579
16220	Casper, WY Natrona County, WY	1.0070
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.9503
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	1.0692
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8611
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9815
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	1.0021
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9913
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN	0.9341

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Marion County, TN	
	Sequatchie County, TN	
16940	Cheyenne, WY	0.9883
	Laramie County, WY	
16974	Chicago-Naperville-Joliet, IL	1.1076
	Cook County, IL	
	DeKalb County, IL	
	DuPage County, IL	
	Grundy County, IL	
	Kane County, IL	
	Kendall County, IL	
	McHenry County, IL	
	Will County, IL	
17020	Chico, CA	1.1845
	Butte County, CA	
17140	Cincinnati-Middletown, OH-KY-IN	1.0031
	Dearborn County, IN	
	Franklin County, IN	
	Ohio County, IN	
	Boone County, KY	
	Bracken County, KY	
	Campbell County, KY	
	Gallatin County, KY	
	Grant County, KY	
	Kenton County, KY	
	Pendleton County, KY	
	Brown County, OH	
	Butler County, OH	
	Clermont County, OH	
	Hamilton County, OH	
	Warren County, OH	
17300	Clarksville, TN-KY	0.8441
	Christian County, KY	
	Trigg County, KY	
	Montgomery County, TN	
	Stewart County, TN	
17420	Cleveland, TN	0.8001
	Bradley County, TN	
	Polk County, TN	
17460	Cleveland-Elyria-Mentor, OH	0.9429
	Cuyahoga County, OH	
	Geauga County, OH	
	Lake County, OH	
	Lorain County, OH	
	Medina County, OH	
17660	Coeur d'Alene, ID	0.9768
	Kootenai County, ID	
17780	College Station-Bryan, TX	1.0046
	Brazos County, TX	
	Burleson County, TX	
	Robertson County, TX	
17820	Colorado Springs, CO	1.0388
	El Paso County, CO	
	Teller County, CO	
17860	Columbia, MO	0.9116
	Boone County, MO	
	Howard County, MO	
17900	Columbia, SC	0.9296
	Calhoun County, SC	
	Fairfield County, SC	
	Kershaw County, SC	
	Lexington County, SC	
	Richland County, SC	
	Saluda County, SC	
17980	Columbus, GA-AL	0.9228
	Russell County, AL	
	Chattahoochee County, GA	
	Harris County, GA	
	Marion County, GA	
	Muscogee County, GA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
18020	Columbus, IN Bartholomew County, IN	1.0087
18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	1.0684
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.9195
18700	Corvallis, OR Benton County, OR	1.1637
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8509
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	1.0422
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.9166
19180	Danville, IL Vermilion County, IL	0.9242
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8804
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8762
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9743
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.8249
19500	Decatur, IL Macon County, IL	0.8457
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.9377
19740	Denver-Aurora-Broomfield, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.1351
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA	1.0206

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Warren County, IA	
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	1.0291
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7834
20100	Dover, DE Kent County, DE	1.0504
20220	Dubuque, IA Dubuque County, IA	0.9381
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.1051
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	1.0173
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	1.0119
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1700
20940	El Centro, CA Imperial County, CA	0.9272
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8872
21140	Elkhart-Goshen, IN	1.0037

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Elkhart County, IN	
21300	Elmira, NY Chemung County, NY	0.8823
21340	El Paso, TX El Paso County, TX	0.9034
21500	Erie, PA Erie County, PA	0.9266
21660	Eugene-Springfield, OR Lane County, OR	1.1671
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.9014
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1756
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.6875
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8644
22140	Farmington, NM San Juan County, NM	0.8344
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9898
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.9282

CBSA Code	Urban Area (Constituent Counties)	Wage Index
22380	Flagstaff, AZ Coconino County, AZ	1.3195
22420	Flint, MI Genesee County, MI	1.1883
22500	Florence, SC Darlington County, SC Florence County, SC	0.8582
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8460
22540	Fond du Lac, WI Fond du Lac County, WI	1.0218
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0762
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0982
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.8315
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.9264
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9532
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	1.0047
23420	Fresno, CA Fresno County, CA	1.1918
23460	Gadsden, AL Etowah County, AL	0.8743
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9496
23580	Gainesville, GA Hall County, GA	0.9650
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9824
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8944
24140	Goldsboro, NC Wayne County, NC	0.9579
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.8224
24300	Grand Junction, CO Mesa County, CO	1.0282
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9708
24500	Great Falls, MT Cascade County, MT	0.8836
24540	Greeley, CO Weld County, CO	1.0131
24580	Green Bay, WI Brown County, WI Kewaunee County, WI	1.0176

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Oconto County, WI	
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9585
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9944
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	1.0556
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.6875
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.9290
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9483
25260	Hanford-Corcoran, CA Kings County, CA	1.1646
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9822
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9546
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1840
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.8106
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.9520
25980	Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA	0.9549
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9198
26180	Honolulu, HI Honolulu County, HI	1.2335
26300	Hot Springs, AR Garland County, AR	0.9524
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.8330
26420	Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	1.0409
26580	Huntington-Ashland, WV-KY-OH	0.9622

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9587
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9981
26900	Indianapolis-Carmel, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	1.0304
26980	Iowa City, IA Johnson County, IA Washington County, IA	1.0099
27060	Ithaca, NY Tompkins County, NY	1.0696
27100	Jackson, MI Jackson County, MI	0.9223
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8659

CBSA Code	Urban Area (Constituent Counties)	Wage Index
27180	Jackson, TN Chester County, TN Madison County, TN	0.9076
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9631
27340	Jacksonville, NC Onslow County, NC	0.8489
27500	Janesville, WI Rock County, WI	0.9732
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.9212
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.8168
27780	Johnstown, PA Cambria County, PA	0.8708
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.8166
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8763
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0857
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0761

CBSA Code	Urban Area (Constituent Counties)	Wage Index
28140	Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	1.0238
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	1.1051
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.9204
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.8461
28740	Kingston, NY Ulster County, NY	0.9908
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.8336
29020	Kokomo, IN Howard County, IN Tipton County, IN	1.0431
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	1.0487
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9711
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.9008
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.8446
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.1080
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	1.1177
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8874
29540	Lancaster, PA Lancaster County, PA	0.9735
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0334
29700	Laredo, TX Webb County, TX	0.8544
29740	Las Cruces, NM Dona Ana County, NM	0.9455

CBSA Code	Urban Area (Constituent Counties)	Wage Index
29820	Las Vegas-Paradise, NV Clark County, NV	1.2830
29940	Lawrence, KS Douglas County, KS	0.9075
30020	Lawton, OK Comanche County, OK	0.8300
30140	Lebanon, PA Lebanon County, PA	0.8588
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	1.0123
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9610
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9402
30620	Lima, OH Allen County, OH	0.9920
30700	Lincoln, NE Lancaster County, NE Seward County, NE	1.0115
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.9053
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.9512
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8514
31020	Longview, WA Cowlitz County, WA	1.1325
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.2734
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.9462
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.9256
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.9013
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA	1.0393

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Monroe County, GA Twiggs County, GA	
31460	Madera-Chowchilla, CA Madera County, CA	0.8417
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1883
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0758
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS	0.8333
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9707
31900	Mansfield, OH Richland County, OH	0.9625
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.6875
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9363
32780	Medford, OR Jackson County, OR	1.0651
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9803
32900	Merced, CA Merced County, CA	1.2823
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0529
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9849
33260	Midland, TX Midland County, TX	1.0097
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0737
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1736
33540	Missoula, MT Missoula County, MT	0.9738
33660	Mobile, AL Mobile County, AL	0.8234
33700	Modesto, CA Stanislaus County, CA	1.3224
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.8200

CBSA Code	Urban Area (Constituent Counties)	Wage Index
33780	Monroe, MI Monroe County, MI	0.9398
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8783
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8947
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7617
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.1055
34620	Muncie, IN Delaware County, IN	0.8870
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0390
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.9234
34900	Napa, CA Napa County, CA	1.5287
34940	Naples-Marco Island, FL Collier County, FL	1.0220
34980	Nashville-Davidson—Murfreesboro--Franklin, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN	1.0248

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN	
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.3197
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.2078
35300	New Haven-Milford, CT New Haven County, CT	1.2212
35380	New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA	0.9617
35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY	1.3756

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Rockland County, NY Westchester County, NY	
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9417
35980	Norwich-New London, CT New London County, CT	1.2057
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.7351
36100	Ocala, FL Marion County, FL	0.9050
36140	Ocean City, NJ Cape May County, NJ	1.0747
36220	Odessa, TX Ector County, TX	1.0431
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9901
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.9414
36500	Olympia, WA Thurston County, WA	1.2197
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE	1.0163

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Sarpy County, NE Saunders County, NE Washington County, NE	
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9468
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9680
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8839
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.3011
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9583
37380	Palm Coast, FL Flagler County, FL	1.0157
37460	Panama City-Lynn Haven-Panama City, FL Bay County, FL	0.8805
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.8161
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8920
37764	Peabody, MA Essex County, MA	1.1499
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8792

CBSA Code	Urban Area (Constituent Counties)	Wage Index
37900	Peoria, IL	0.9684
	Marshall County, IL	
	Peoria County, IL	
	Stark County, IL	
	Tazewell County, IL	
	Woodford County, IL	
37964	Philadelphia, PA	1.1359
	Bucks County, PA	
	Chester County, PA	
	Delaware County, PA	
	Montgomery County, PA	
	Philadelphia County, PA	
38060	Phoenix-Mesa-Scottsdale, AZ	1.1244
	Maricopa County, AZ	
	Pinal County, AZ	
38220	Pine Bluff, AR	0.7701
	Cleveland County, AR	
	Jefferson County, AR	
	Lincoln County, AR	
38300	Pittsburgh, PA	0.9123
	Allegheny County, PA	
	Armstrong County, PA	
	Beaver County, PA	
	Butler County, PA	
	Fayette County, PA	
	Washington County, PA	
	Westmoreland County, PA	
38340	Pittsfield, MA	1.1273
	Berkshire County, MA	
38540	Pocatello, ID	0.9772
	Bannock County, ID	
	Power County, ID	
38660	Ponce, PR	0.6875
	Juana Díaz Municipio, PR	
	Ponce Municipio, PR	
	Villalba Municipio, PR	
38860	Portland-South Portland-Biddeford, ME	1.0775
	Cumberland County, ME	
	Sagadahoc County, ME	
	York County, ME	
38900	Portland-Vancouver-Beaverton, OR-WA	1.2162
	Clackamas County, OR	
	Columbia County, OR	
	Multnomah County, OR	
	Washington County, OR	
	Yamhill County, OR	
	Clark County, WA	
	Skamania County, WA	
38940	Port St. Lucie, FL	1.0467
	Martin County, FL	
	St. Lucie County, FL	
39100	Poughkeepsie-Newburgh-Middletown, NY	1.1864
	Dutchess County, NY	
	Orange County, NY	
39140	Prescott, AZ	1.0705
	Yavapai County, AZ	
39300	Providence-New Bedford-Fall River, RI-MA	1.1404
	Bristol County, MA	
	Bristol County, RI	
	Kent County, RI	
	Newport County, RI	
	Providence County, RI	
	Washington County, RI	
39340	Provo-Orem, UT	1.0099
	Juab County, UT	
	Utah County, UT	
39380	Pueblo, CO	0.9065
	Pueblo County, CO	
39460	Punta Gorda, FL	0.9281
	Charlotte County, FL	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
39540	Racine, WI	0.9914
	Racine County, WI	
39580	Raleigh-Cary, NC	1.0221
	Franklin County, NC	
	Johnston County, NC	
	Wake County, NC	
39660	Rapid City, SD	1.0626
	Meade County, SD	
	Pennington County, SD	
39740	Reading, PA	0.9798
	Berks County, PA	
39820	Redding, CA	1.4850
	Shasta County, CA	
39900	Reno-Sparks, NV	1.0879
	Storey County, NV	
	Washoe County, NV	
40060	Richmond, VA	1.0071
	Amelia County, VA	
	Caroline County, VA	
	Charles City County, VA	
	Chesterfield County, VA	
	Cumberland County, VA	
	Dinwiddie County, VA	
	Goochland County, VA	
	Hanover County, VA	
	Henrico County, VA	
	King and Queen County, VA	
	King William County, VA	
	Louisa County, VA	
	New Kent County, VA	
	Powhatan County, VA	
	Prince George County, VA	
	Sussex County, VA	
	Colonial Heights City, VA	
	Hopewell City, VA	
	Petersburg City, VA	
	Richmond City, VA	
40140	Riverside-San Bernardino-Ontario, CA	1.1937
	Riverside County, CA	
	San Bernardino County, CA	
40220	Roanoke, VA	0.9172
	Botetourt County, VA	
	Craig County, VA	
	Franklin County, VA	
	Roanoke County, VA	
	Roanoke City, VA	
	Salem City, VA	
40340	Rochester, MN	1.1779
	Dodge County, MN	
	Olmsted County, MN	
	Wabasha County, MN	
40380	Rochester, NY	0.9228
	Livingston County, NY	
	Monroe County, NY	
	Ontario County, NY	
	Orleans County, NY	
	Wayne County, NY	
40420	Rockford, IL	1.0738
	Boone County, IL	
	Winnebago County, IL	
40484	Rockingham County, NH	1.0710
	Rockingham County, NH	
	Strafford County, NH	
40580	Rocky Mount, NC	0.9356
	Edgecombe County, NC	
	Nash County, NC	
40660	Rome, GA	0.9430
	Floyd County, GA	
40900	Sacramento--Arden-Arcade--Roseville, CA	1.4886
	El Dorado County, CA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Placer County, CA Sacramento County, CA Yolo County, CA	
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9649
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1748
41100	St. George, UT Washington County, UT	0.9769
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0777
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9628
41420	Salem, OR Marion County, OR	1.1608

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Polk County, OR	
41500	Salinas, CA Monterey County, CA	1.6085
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9636
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9919
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8371
41700	San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.9368
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.2431
41780	Sandusky, OH Erie County, OH	0.9401
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.6790
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.6875

CBSA Code	Urban Area (Constituent Counties)	Wage Index
41940	San Jose-Sunnyvale-Santa Clara, CA	1.7351
	San Benito County, CA	
	Santa Clara County, CA	
41980	San Juan-Caguas-Guaynabo, PR	0.6875
	Aguas Buenas Municipio, PR	
	Aibonito Municipio, PR	
	Arecibo Municipio, PR	
	Barceloneta Municipio, PR	
	Barranquitas Municipio, PR	
	Bayamón Municipio, PR	
	Caguas Municipio, PR	
	Camuy Municipio, PR	
	Canóvanas Municipio, PR	
	Carolina Municipio, PR	
	Cataño Municipio, PR	
	Cayey Municipio, PR	
	Ciales Municipio, PR	
	Cidra Municipio, PR	
	Comerío Municipio, PR	
	Corozal Municipio, PR	
	Dorado Municipio, PR	
	Florida Municipio, PR	
	Guaynabo Municipio, PR	
	Gurabo Municipio, PR	
	Hatillo Municipio, PR	
	Humacao Municipio, PR	
	Juncos Municipio, PR	
	Las Piedras Municipio, PR	
	Loíza Municipio, PR	
	Manatí Municipio, PR	
	Maunabo Municipio, PR	
	Morovis Municipio, PR	
	Naguabo Municipio, PR	
	Naranjito Municipio, PR	
	Orocovis Municipio, PR	
	Quebradillas Municipio, PR	
	Río Grande Municipio, PR	
	San Juan Municipio, PR	
	San Lorenzo Municipio, PR	
	Toa Alta Municipio, PR	
	Toa Baja Municipio, PR	
	Trujillo Alto Municipio, PR	
	Vega Alta Municipio, PR	
	Vega Baja Municipio, PR	
	Yabucoa Municipio, PR	
42020	San Luis Obispo-Paso Robles, CA	1.3275
	San Luis Obispo County, CA	
42044	Santa Ana-Anaheim-Irvine, CA	1.2663
	Orange County, CA	
42060	Santa Barbara-Santa Maria-Goleta, CA	1.2918
	Santa Barbara County, CA	
42100	Santa Cruz-Watsonville, CA	1.7701
	Santa Cruz County, CA	
42140	Santa Fe, NM	1.1311
	Santa Fe County, NM	
42220	Santa Rosa-Petaluma, CA	1.6808
	Sonoma County, CA	
42340	Savannah, GA	0.9565
	Bryan County, GA	
	Chatham County, GA	
	Effingham County, GA	
42540	Scranton--Wilkes-Barre, PA	0.8859
	Lackawanna County, PA	
	Luzerne County, PA	
	Wyoming County, PA	
42644	Seattle-Bellevue-Everett, WA	1.2245
	King County, WA	
	Snohomish County, WA	
42680	Sebastian-Vero Beach, FL	0.9903
	Indian River County, FL	
43100	Sheboygan, WI	0.9695

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Sheboygan County, WI	
43300	Sherman-Denison, TX	0.8530
	Grayson County, TX	
43340	Shreveport-Bossier City, LA	0.8867
	Bossier Parish, LA	
	Caddo Parish, LA	
	De Soto Parish, LA	
43580	Sioux City, IA-NE-SD	0.9619
	Woodbury County, IA	
	Dakota County, NE	
	Dixon County, NE	
	Union County, SD	
43620	Sioux Falls, SD	0.9502
	Lincoln County, SD	
	McCook County, SD	
	Minnehaha County, SD	
	Turner County, SD	
43780	South Bend-Mishawaka, IN-MI	1.0249
	St. Joseph County, IN	
	Cass County, MI	
43900	Spartanburg, SC	0.9880
	Spartanburg County, SC	
44060	Spokane, WA	1.1047
	Spokane County, WA	
44100	Springfield, IL	1.0096
	Menard County, IL	
	Sangamon County, IL	
44140	Springfield, MA	1.0972
	Franklin County, MA	
	Hampden County, MA	
	Hampshire County, MA	
44180	Springfield, MO	0.8941
	Christian County, MO	
	Dallas County, MO	
	Greene County, MO	
	Polk County, MO	
	Webster County, MO	
44220	Springfield, OH	0.9726
	Clark County, OH	
44300	State College, PA	0.9621
	Centre County, PA	
44700	Stockton, CA	1.3043
	San Joaquin County, CA	
44940	Sumter, SC	0.8623
	Sumter County, SC	
45060	Syracuse, NY	1.0350
	Madison County, NY	
	Onondaga County, NY	
	Oswego County, NY	
45104	Tacoma, WA	1.1841
	Pierce County, WA	
45220	Tallahassee, FL	0.8891
	Gadsden County, FL	
	Jefferson County, FL	
	Leon County, FL	
	Wakulla County, FL	
45300	Tampa-St. Petersburg-Clearwater, FL	0.9501
	Hernando County, FL	
	Hillsborough County, FL	
	Pasco County, FL	
	Pinellas County, FL	
45460	Terre Haute, IN	0.9584
	Clay County, IN	
	Sullivan County, IN	
	Vermillion County, IN	
	Vigo County, IN	
45500	Texarkana, TX-Texarkana, AR	0.8581
	Miller County, AR	
	Bowie County, TX	
45780	Toledo, OH	1.0092

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Fulton County, OH	
	Lucas County, OH	
	Ottawa County, OH	
	Wood County, OH	
45820	Topeka, KS	0.9547
	Jackson County, KS	
	Jefferson County, KS	
	Osage County, KS	
	Shawnee County, KS	
	Wabaunsee County, KS	
45940	Trenton-Ewing, NJ	1.1161
	Mercer County, NJ	
46060	Tucson, AZ	1.0054
	Pima County, AZ	
46140	Tulsa, OK	0.9162
	Creek County, OK	
	Okmulgee County, OK	
	Osage County, OK	
	Pawnee County, OK	
	Rogers County, OK	
	Tulsa County, OK	
	Wagoner County, OK	
46220	Tuscaloosa, AL	0.9200
	Greene County, AL	
	Hale County, AL	
	Tuscaloosa County, AL	
46340	Tyler, TX	0.8792
	Smith County, TX	
46540	Utica-Rome, NY	0.8948
	Herkimer County, NY	
	Oneida County, NY	
46660	Valdosta, GA	0.8403
	Brooks County, GA	
	Echols County, GA	
	Lanier County, GA	
	Lowndes County, GA	
46700	Vallejo-Fairfield, CA	1.5796
	Solano County, CA	
47020	Victoria, TX	0.8519
	Calhoun County, TX	
	Goliad County, TX	
	Victoria County, TX	
47220	Vineland-Millville-Bridgeton, NJ	1.0796
	Cumberland County, NJ	
47260	Virginia Beach-Norfolk-Newport News, VA-NC	0.9477
	Currituck County, NC	
	Gloucester County, VA	
	Isle of Wight County, VA	
	James City County, VA	
	Mathews County, VA	
	Surry County, VA	
	York County, VA	
	Chesapeake City, VA	
	Hampton City, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
47300	Visalia-Porterville, CA	1.0611
	Tulare County, CA	
47380	Waco, TX	0.8861
	McLennan County, TX	
47580	Warner Robins, GA	0.9259
	Houston County, GA	
47644	Warren-Troy-Farmington Hills, MI	1.0372
	Lapeer County, MI	
	Livingston County, MI	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Macomb County, MI	
	Oakland County, MI	
	St. Clair County, MI	
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	1.1510
	District of Columbia, DC	
	Calvert County, MD	
	Charles County, MD	
	Prince George's County, MD	
	Arlington County, VA	
	Clarke County, VA	
	Fairfax County, VA	
	Fauquier County, VA	
	Loudoun County, VA	
	Prince William County, VA	
	Spotsylvania County, VA	
	Stafford County, VA	
	Warren County, VA	
	Alexandria City, VA	
	Fairfax City, VA	
	Falls Church City, VA	
	Fredericksburg City, VA	
	Manassas City, VA	
	Manassas Park City, VA	
	Jefferson County, WV	
47940	Waterloo-Cedar Falls, IA	0.9010
	Black Hawk County, IA	
	Bremer County, IA	
	Grundy County, IA	
48140	Wausau, WI	0.9985
	Marathon County, WI	
48260	Weirton-Steubenville, WV-OH	0.7793
	Jefferson County, OH	
	Brooke County, WV	
	Hancock County, WV	
48300	Wenatchee, WA	1.0280
	Chelan County, WA	
	Douglas County, WA	
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	1.0449
	Palm Beach County, FL	
48540	Wheeling, WV-OH	0.7266
	Belmont County, OH	
	Marshall County, WV	
	Ohio County, WV	
48620	Wichita, KS	0.9539
	Butler County, KS	
	Harvey County, KS	
	Sedgwick County, KS	
	Sumner County, KS	
48660	Wichita Falls, TX	0.9728
	Archer County, TX	
	Clay County, TX	
	Wichita County, TX	
48700	Williamsport, PA	0.8332
	Lycoming County, PA	
48864	Wilmington, DE-MD-NJ	1.1164
	New Castle County, DE	
	Cecil County, MD	
	Salem County, NJ	
48900	Wilmington, NC	0.9505
	Brunswick County, NC	
	New Hanover County, NC	
	Pender County, NC	
49020	Winchester, VA-WV	1.0341
	Frederick County, VA	
	Winchester City, VA	
	Hampshire County, WV	
49180	Winston-Salem, NC	0.9470
	Davie County, NC	
	Forsyth County, NC	
	Stokes County, NC	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Yadkin County, NC	
49340	Worcester, MA Worcester County, MA	1.1729
49420	Yakima, WA Yakima County, WA	1.0523
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.6875
49620	York-Hanover, PA York County, PA	0.9836
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.9180
49700	Yuba City, CA	1.1915
49740	Yuma, AZ Yuma County, AZ	0.9671

ADDENDUM H: CPT/HCPCS Imaging Codes Defined By Section 5102(b) of the DRA

HCPCS/ CPT*	Short Descriptor
31620	Endobronchial us add-on
37250	Iv us first vessel add-on
37251	Iv us each add vessel add-on
51798	Us urine capacity measure
70010	Contrast x-ray of brain
70015	Contrast x-ray of brain
70030	X-ray eye for foreign body
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70170	X-ray exam of tear duct
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70332	X-ray exam of jaw joint
70336	Magnetic image, jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex
70373	Contrast x-ray of larynx
70380	X-ray exam of salivary gland
70390	X-ray exam of salivary duct
70450	Ct head/brain w/o dye

HCPCS/ CPT*	Short Descriptor
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70557	Mri brain w/o dye
70558	Mri brain w/dye
70559	Mri brain w/o & w/dye
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray

HCPCS/ CPT*	Short Descriptor
71040	Contrast x-ray of bronchi
71060	Contrast x-ray of bronchi
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
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye

HCPCS/ CPT*	Short Descriptor
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72159	Mr angio spine w/o&w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
72240	Contrast x-ray of neck spine
72255	Contrast x-ray, thorax spine
72265	Contrast x-ray, lower spine
72270	Contrast x-ray, spine
72275	Epidurography
72285	X-ray c/t spine disk
72291	Percut vertebroplasty fluor
72293	Percut vertebroplasty, ct
72295	X-ray of lower spine disk
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
73040	Contrast x-ray 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
73085	Contrast x-ray of elbow
73090	X-ray exam of forearm

HCPCS/ CPT*	Short Descriptor
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73115	Contrast x-ray of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73225	Mr angio upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73525	Contrast x-ray of hip
73530	X-ray exam of hip
73540	X-ray exam of pelvis & hips
73542	X-ray exam, sacroiliac joint
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
73580	Contrast x-ray of knee joint
73590	X-ray exam of lower leg
73592	X-ray exam of leg, infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73615	Contrast x-ray 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)

HCPCS/ CPT*	Short Descriptor
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74190	X-ray exam of peritoneum
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
74241	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
74251	X-ray exam of small bowel
74260	X-ray exam of small bowel
74261	Ct colonography, w/o dye
74262	Ct colonography, w/dye
74263	Ct colonography, screen

HCPCS/ CPT*	Short Descriptor
74270	Contrast x-ray exam of colon
74280	Contrast x-ray exam of colon
74283	Contrast x-ray exam of colon
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74300	X-ray bile ducts/pancreas
74301	X-rays at surgery add-on
74305	X-ray bile ducts/pancreas
74320	Contrast x-ray of bile ducts
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
74355	X-ray guide, intestinal tube
74360	X-ray guide, GI dilation
74363	X-ray, bile duct dilation
74400	Contrst x-ray, urinary tract
74410	Contrst x-ray, urinary tract
74415	Contrst x-ray, urinary tract
74420	Contrst x-ray, urinary tract
74425	Contrst x-ray, urinary tract
74430	Contrast x-ray, bladder
74440	X-ray, male genital tract
74445	X-ray exam of penis
74450	X-ray, urethra/bladder
74455	X-ray, urethra/bladder
74470	X-ray exam of kidney lesion
74475	X-ray control, cath insert
74480	X-ray control, cath insert
74485	X-ray guide, GU dilation
74710	X-ray measurement of pelvis
74740	X-ray, female genital tract
74742	X-ray, fallopian tube
74775	X-ray exam of perineum
75557	Cardiac MRI w/o contrast
75559	Cardiac MRI w/ stress imaging
75561	Cardiac MRI w/ & w/o contrast
75563	Cardiac MRI w/ stress imaging
75565	Card mri vel flw map add-on

HCPCS/ CPT*	Short Descriptor
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
75600	Contrast x-ray exam of aorta
75605	Contrast x-ray exam of aorta
75625	Contrast x-ray exam of aorta
75630	X-ray aorta, leg arteries
75635	Ct angio abdominal arteries
75650	Artery x-rays, head & neck
75658	Artery x-rays, arm
75660	Artery x-rays, head & neck
75662	Artery x-rays, head & neck
75665	Artery x-rays, head & neck
75671	Artery x-rays, head & neck
75676	Artery x-rays, neck
75680	Artery x-rays, neck
75685	Artery x-rays, spine
75705	Artery x-rays, spine
75710	Artery x-rays, arm/leg
75716	Artery x-rays, arms/legs
75722	Artery x-rays, kidney
75724	Artery x-rays, kidneys
75726	Artery x-rays, abdomen
75731	Artery x-rays, adrenal gland
75733	Artery x-rays, adrenals
75736	Artery x-rays, pelvis
75741	Artery x-rays, lung
75743	Artery x-rays, lungs
75746	Artery x-rays, lung
75756	Artery x-rays, chest
75774	Artery x-ray, each vessel
75790	Visualize A-V shunt
75791	Av dialysis shunt imaging
75801	Lymph vessel x-ray, arm/leg
75803	Lymph vessel x-ray,arms/legs
75805	Lymph vessel x-ray, trunk
75807	Lymph vessel x-ray, trunk
75809	Nonvascular shunt, x-ray
75810	Vein x-ray, spleen/liver
75820	Vein x-ray, arm/leg
75822	Vein x-ray, arms/legs
75825	Vein x-ray, trunk

HCPCS/ CPT*	Short Descriptor
75827	Vein x-ray, chest
75831	Vein x-ray, kidney
75833	Vein x-ray, kidneys
75840	Vein x-ray, adrenal gland
75842	Vein x-ray, adrenal glands
75860	Vein x-ray, neck
75870	Vein x-ray, skull
75872	Vein x-ray, skull
75880	Vein x-ray, eye socket
75885	Vein x-ray, liver
75887	Vein x-ray, liver
75889	Vein x-ray, liver
75891	Vein x-ray, liver
75893	Venous sampling by catheter
75894	X-rays, transcath therapy
75896	X-rays, transcath therapy
75898	Follow-up angiography
75900	Intravascular cath exchange
75901	Remove cva device obstruct
75902	Remove cva lumen obstruct
75940	X-ray placement, vein filter
75945	Intravascular us
75946	Intravascular us add-on
75953	Abdom aneurysm endovas rpr
75956	Xray, endovasc thor ao repr
75957	Xray, endovasc thor ao repr
75958	Xray, place prox ext thor ao
75959	Xray, place dist ext thor ao
75960	Transcath iv stent rs&i
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 xray exam bile duct
75982	Contrast xray exam bile duct
75984	Xray control catheter change
75989	Abscess drainage under x-ray
75992	Atherectomy, x-ray exam
76000	Fluoroscope examination

HCPCS/ CPT*	Short Descriptor
76001	Fluoroscope exam, extensive
76010	X-ray, nose to rectum
76080	X-ray exam of fistula
76098	X-ray exam, breast specimen
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76140	X-ray consultation
76150	X-ray exam, dry process
76350	Special x-ray contrast study
76376	3d render w/o postprocess
76377	3d rendering w/postprocess
76380	CAT scan follow-up study
76390	Mr spectroscopy
76496	Fluoroscopic procedure
76497	Ct procedure
76498	Mri procedure
76506	Echo exam of head
76510	Ophth us, b & quant a
76511	Ophth us, quant a only
76512	Ophth us, b w/non-quant a
76513	Echo exam of eye, water bath
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
76529	Echo exam of eye
76536	Us exam of head and neck
76604	Us exam, chest, b-scan
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
76778	Us exam kidney transplant
76800	Us exam, spinal canal
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, add'l fetus
76805	Ob us >/= 14 wks, sngl fetus
76810	Ob us >/= 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus

HCPCS/ CPT*	Short Descriptor
76812	Ob us, detailed, addl fetus
76815	Ob us, limited, fetus(s)
76816	Ob us, follow-up, per fetus
76817	Transvaginal us, obstetric
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76830	Transvaginal us, non-ob
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76872	Us, transrectal
76873	Echograp trans r, pros study
76880	Us exam, extremity
76885	Us exam infant hips, dynamic
76886	Us exam infant hips, static
76930	Echo guide, cardiocentesis
76932	Echo guide for heart biopsy
76936	Echo guide for artery repair
76937	Us guide, vascular access
76940	Us guide, tissue ablation
76941	Echo guide for transfusion
76942	Echo guide for biopsy
76945	Echo guide, villus sampling
76946	Echo guide for amniocentesis
76948	Echo guide, ova aspiration
76950	Echo guidance radiotherapy
76965	Echo guidance radiotherapy
76970	Ultrasound exam follow-up
76975	GI endoscopic ultrasound
76977	Us bone density measure
76998	Ultrasound guide intraoper
77001	Fluoroguide for vein device
77002	Needle localization by x-ray
77003	Fluoroguide for spine inject
77011	Ct scan for localization
77012	Ct scan for needle biopsy

HCPCS/ CPT*	Short Descriptor
77013	Ct guide for tissue ablation
77014	Ct scan for therapy guide
77021	Mr guidance for needle place
77022	Mri for tissue ablation
77031	Stereotactic breast biopsy
77032	X-ray of needle wire, breast
77053	X-ray of mammary duct
77054	X-ray of mammary ducts
77058	Magnetic image, breast
77059	Magnetic image, both breasts
77071	X-ray stress view
77072	X-rays for bone age
77073	X-rays, bone evaluation
77074	X-rays, bone survey
77075	X-rays, bone survey
77076	X-rays, bone evaluation
77077	Joint survey, single view
77078	Ct bone density, axial
77079	Ct bone density, peripheral
77080	Dxa bone density, axial
77081	Dxa bone density/peripheral
77082	Dxa bone density/v-fracture
77083	Radiographic absorptiometry
77084	Magnetic image, bone marrow
77417	Radiology port film(s)
77421	Stereoscopic x-ray guidance
78006	Thyroid imaging with uptake
78007	Thyroid image, mult uptakes
78010	Thyroid imaging
78011	Thyroid imaging with flow
78015	Thyroid met imaging
78016	Thyroid met imaging/studies
78018	Thyroid met imaging, body
78020	Thyroid met uptake
78070	Parathyroid nuclear imaging
78075	Adrenal nuclear imaging
78102	Bone marrow imaging, ltd
78103	Bone marrow imaging, mult
78104	Bone marrow imaging, body
78135	Red cell survival kinetics
78140	Red cell sequestration
78185	Spleen imaging

HCPCS/ CPT*	Short Descriptor
78190	Platelet survival, kinetics
78195	Lymph system imaging
78201	Liver imaging
78202	Liver imaging with flow
78205	Liver imaging (3D)
78206	Liver image (3d) with flow
78215	Liver and spleen imaging
78216	Liver & spleen image/flow
78220	Liver function study
78223	Hepatobiliary imaging
78230	Salivary gland imaging
78231	Serial salivary imaging
78232	Salivary gland function exam
78258	Esophageal motility study
78261	Gastric mucosa imaging
78262	Gastroesophageal reflux exam
78264	Gastric emptying study
78278	Acute GI blood loss imaging
78282	GI protein loss exam
78290	Meckel's divert exam
78291	Leveen/shunt patency exam
78300	Bone imaging, limited area
78305	Bone imaging, multiple areas
78306	Bone imaging, whole body
78315	Bone imaging, 3 phase
78320	Bone imaging (3D)
78350	Bone mineral, single photon
78351	Bone mineral, dual photon
78428	Cardiac shunt imaging
78445	Vascular flow imaging
78451	Ht muscle image spect, sing
78452	Ht muscle image spect, mult
78453	Ht muscle image,planar,sing
78454	Ht musc image, planar, mult
78456	Acute venous thrombus image
78457	Venous thrombosis imaging
78458	Ven thrombosis images, bilat
78459	Heart muscle imaging (PET)
78466	Heart infarct image
78468	Heart infarct image (ef)
78469	Heart infarct image (3D)

HCPCS/ CPT*	Short Descriptor
78472	Gated heart, planar, single
78473	Gated heart, multiple
78481	Heart first pass, single
78483	Heart first pass, multiple
78491	Heart image (pet), single
78492	Heart image (pet), multiple
78494	Heart image, spect
78496	Heart first pass add-on
78580	Lung perfusion imaging
78584	Lung V/Q image single breath
78585	Lung V/Q imaging
78586	Aerosol lung image, single
78587	Aerosol lung image, multiple
78588	Perfusion lung image
78591	Vent image, 1 breath, 1 proj
78593	Vent image, 1 proj, gas
78594	Vent image, mult proj, gas
78596	Lung differential function
78600	Brain imaging, ltd static
78601	Brain imaging, ltd w/flow
78605	Brain imaging, complete
78606	Brain imaging, compl w/flow
78607	Brain imaging (3D)
78608	Brain imaging (PET)
78609	Brain imaging (PET)
78610	Brain flow imaging only
78630	Cerebrospinal fluid scan
78635	CSF ventriculography
78645	CSF shunt evaluation
78647	Cerebrospinal fluid scan
78650	CSF leakage imaging
78660	Nuclear exam of tear flow
78700	Kidney imaging, static
78701	Kidney imaging with flow
78704	Imaging renogram
78707	Kidney flow/function image
78708	Kidney flow/function image
78709	Kidney flow/function image
78710	Kidney imaging (3D)
78715	Renal vascular flow exam
78730	Urinary bladder retention
78740	Ureteral reflux study

HCPCS/ CPT*	Short Descriptor
78760	Testicular imaging
78761	Testicular imaging/flow
78800	Tumor imaging, limited area
78801	Tumor imaging, mult areas
78802	Tumor imaging, whole body
78803	Tumor imaging (3D)
78804	Tumor imaging, whole body
78805	Abscess imaging, ltd area
78806	Abscess imaging, whole body
78807	Nuclear localization/abscess
78808	Iv inj ra drug dx study
78811	Tumor imaging (pet), limited
78812	Tumor image (pet)/skul-thigh
78813	Tumor image (pet) full body
78814	Tumor image pet/ct, limited
78815	Tumorimage pet/ct skul-thigh
78816	Tumor image pet/ct full body
92135	Scanning computer ophthalmic
92235	Fluorscein angioscopy
92240	IDC green angiography
92250	Fundus photography
92285	External ocular photography
92286	Anterior segment photography
93303	Echo transthoracic
93304	Echo transthoracic
93306	Tte w/doppler, complete
93307	Echo exam of heart
93308	Echo exam of heart
93312	Echo transesophageal
93313	Echo transesophageal
93314	Echo transesophageal
93315	Echo transesophageal
93316	Echo transesophageal
93317	Echo transesophageal
93318	Echo transesophageal intraop
93320	Doppler echo exam, heart
93321	Doppler echo exam, heart
93325	Doppler color flow add-on
93350	Echo transthoracic
93351	Stress tte complete
93352	Admin ecg contrast agent

HCPCS/ CPT*	Short Descriptor
93555	Imaging, cardiac cath
93556	Imaging, cardiac cath
93571	Heart flow reserve measure
93572	Heart flow reserve measure
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd, vasoreactivity study
93892	Tcd, emboli detect w/o inj
93893	Tcd, emboli detect w/inj
93925	Lower extremity study
93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing
0028T	Dexa body composition study
0042T	Ct perfusion w/contrast, cbf
0066T	Ct colonography;screen
0067T	Ct colonography;dx
0080T	Endovasc aort repr rad s&i
0081T	Endovasc visc extnsn s&i
0144T	CT heart wo dye; qual calc
0145T	CT heart w/wo dye funct
0146T	CCTA w/wo dye
0147T	CCTA w/wo, quan calcium
0148T	CCTA w/wo, strxr
0149T	CCTA w/wo, strxr quan calc
0150T	CCTA w/wo, disease strxr
0151T	CT heart funct add-on
0152T	Computer chest add-on
G0120	Colon ca scrn; barium enema
G0122	Colon ca scrn; barium enema
G0130	Single energy x-ray study
G0219	PET img wholbod melano

HCPCS/ CPT*	Short Descriptor
	nonco
G0235	PET not otherwise specified
G0275	Renal angio, cardiac cath
G0278	Iliac art angio,cardiac cath
G0288	Recon, CTA for surg plan
G0365	Vessel mapping hemo access

ADDENDUM I: List of CPT[1]/HCPCS Codes Used To Define Certain Designated Health Service Categories[2] Under Section 1877 of the Social Security Act

CLINICAL LABORATORY SERVICES	
INCLUDE CPT codes for all clinical laboratory services in the 80000 series, except EXCLUDE CPT codes for the following blood component collection services:	
86890	Autologous blood process
86891	Autologous blood, op salvage
86927	Plasma, fresh frozen
86930	Frozen blood prep
86931	Frozen blood thaw
86932	Frozen blood freeze/thaw
86945	Blood product/irradiation
86950	Leukacyte transfusion
86960	Vol reduction of blood/prod
86965	Pooling blood platelets
86985	Split blood or products
INCLUDE the following CPT and HCPCS level 2 codes for other clinical laboratory services:	
0030T	Antiprothrombin antibody
0103T	Holotranscobalamin
0104T	At rest cardio gas rebreathe
0111T	RBC membranes fatty acids
0140T	Exhaled breath condensate ph
36415	Routine venipuncture
78110	Plasma volume, single
78111	Plasma volume, multiple
78120	Red cell mass, single
78121	Red cell mass, multiple
78122	Blood volume
78130	Red cell survival study
78191	Platelet survival
78267	Breath tst attain/anal c-14
78268	Breath test analysis c-14
78270	Vit B-12 absorption exam
78271	Vit B-12 absrp exam, int fac
78272	Vit B-12 absorp, combined
78725	Kidney function study
G0027	Semen analysis
G0103	Psa screening
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0306	CBC/diffwbc w/o platelet
G0307	CBC without platelet
G0328	Fecal blood scrn immunoassay
G0416	Sat biopsy prostate 1-20 spc
G0417	Sat biopsy prostate 21-40
G0418	Sat biopsy prostate 41-60
G0419	Sat biopsy prostate: >60
G0430	Drug screen multi class
G0431	Drug screen single class
G9143	Warfarin respon genetic test
P2028	Cephalin floculation test
P2029	Congo red blood test
P2033	Blood thymol turbidity
P2038	Blood mucoprotein
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys
P9612	Catheterize for urine spec
P9615	Urine specimen collect mult
Q0111	Wet mounts/ w preparations
Q0112	Potassium hydroxide preps
Q0113	Pinworm examinations
Q0114	Fern test
Q0115	Post-coital mucous exam
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES	
INCLUDE the following CPT and HCPCS codes for physical therapy/occupational therapy/outpatient speech-language pathology services:	
0019T	Extracorp shock wv tx,ms nos
0183T	Wound ultrasound

64550	Apply neurostimulator
90901	Biofeedback train, any meth
90911	Biofeedback peri/uro/rectal
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92526	Oral function therapy
92597	Oral speech device eval
92607	Ex for speech device rx, 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
92610	Evaluate swallowing function
92611	Motion fluoroscopy/swallow
92612	Endoscopy swallow tst (fees)
92614	Laryngoscopic sensory test
92616	Fees w/laryngeal sense test
93797	Cardiac rehab
93798	Cardiac rehab/monitor
94667	Chest wall manipulation
94668	Chest wall manipulation
95831	Limb muscle testing, manual
95832	Hand muscle testing, manual
95833	Body muscle testing, manual
95834	Body muscle testing, manual
95851	Range of motion measurements
95852	Range of motion measurements
96000	Motion analysis, video/3d
96001	Motion test w/ft press meas
96002	Dynamic surface emg
96003	Dynamic fine wire emg
96105	Assessment of aphasia
96110	Developmental test, lim
96111	Developmental test, extend
96125	Cognitive test by HC pro
97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97010	Hot or cold packs therapy
97012	Mechanical traction therapy

97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg, microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97039	Physical therapy treatment
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97139	Physical medicine procedure
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97532	Cognitive skills development
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97545	Work hardening
97546	Work hardening add-on
97597	Active wound care/20cm or <
97598	Active wound care > 20cm
97602	Wound(s) care non-selective
97605	Neg press wound tx, < 50 cm
97606	Neg press wound tx, > 50 cm
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/O for orthotic/prosth use
97799	Physical medicine procedure
G0281	Elec stim unattend for press

G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
INCLUDE the following CPT and HCPCS codes:	
0042T	Ct perfusion w/contrast, cbf
0159T	Cad breast mri
0174T	Cad cxr with interp
0175T	Cad cxr remote
51798	Us urine capacity measure
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70336	Magnetic image, jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex
70380	X-ray exam of salivary gland
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye

70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70554	Fmri brain by tech
70555	Fmri brain by phys/psych
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone

71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye

72158	Mri lumbar spine w/o & w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73090	X-ray exam of forearm
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73500	X-ray exam of hip

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
73590	X-ray exam of lower leg
73592	X-ray exam of leg, infant
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
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74210	Contrst x-ray exam of throat

74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74240	X-ray exam, upper gi tract
74241	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
74261	Ct colonography, w/o dye
74262	Ct colonography, w/dye
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74710	X-ray measurement of pelvis
75557	Cardiac MRI for morph
75559	Cardiac MRI w/stress img
75561	Cardiac MRI for morph w/dye
75563	Card MRI w/stress img & dye
75565	Card MRI vel flw map add-on
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
75635	Ct angio abdominal arteries
76000	Fluoroscope examination
76010	X-ray, nose to rectum
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76150	X-ray exam, dry process
76376	3d render w/o postprocess
76377	3d rendering w/postprocess
76380	CAT scan follow-up study
76499	Radiographic procedure
76506	Echo exam of head
76510	Ophth us, b & quant a
76511	Ophth us, quant a only
76512	Ophth us, b w/non-quant a

76513	Echo exam of eye, water bath
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
76536	Us exam of head and neck
76604	Us exam, chest
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/Doppler
76800	Us exam, spinal canal
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, add'l fetus
76805	Ob us >/= 14 wks, sngl fetus
76810	Ob us >/= 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus
76812	Ob us, detailed, addl fetus
76815	Ob us, limited, fetus(s)
76816	Ob us, follow-up, per fetus
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76880	Us exam, extremity
76885	Us exam infant hips, dynamic
76886	Us exam infant hips, static
76970	Ultrasound exam follow-up
76977	Us bone density measure
76999	Echo examination procedure
77014	Ct scan for therapy guide
77051	Computer dx mammogram add-on

77052	Comp screen mammogram add-on
77055	Mammogram, one breast
77056	Mammogram, both breasts
77057	Mammogram, screening
77058	Mri, one breast
77059	Mri, both breasts
77071	X-ray stress view
77072	X-rays for bone age
77073	X-rays, bone length studies
77074	X-rays, bone survey, limited
77075	X-rays, bone survey complete
77076	X-rays, bone survey, infant
77077	Joint survey, single view
77078	Ct bone density, axial
77079	Ct bone density, peripheral
77080	Dxa bone density, axial
77081	Dxa bone density/peripheral
77082	Dxa bone density, vert fx
77083	Radiographic absorptiometry
77084	Magnetic image, bone marrow
78006	Thyroid imaging with uptake
78007	Thyroid image, mult uptakes
78010	Thyroid imaging
78011	Thyroid imaging with flow
78015	Thyroid met imaging
78016	Thyroid met imaging/studies
78018	Thyroid met imaging, body
78020	Thyroid met uptake
78070	Parathyroid nuclear imaging
78075	Adrenal nuclear imaging
78099	Endocrine nuclear procedure
78102	Bone marrow imaging, ltd
78103	Bone marrow imaging, mult
78104	Bone marrow imaging, body
78135	Red cell survival kinetics
78140	Red cell sequestration
78185	Spleen imaging
78190	Platelet survival, kinetics
78195	Lymph system imaging
78199	Blood/lymph nuclear exam

78201	Liver imaging
78202	Liver imaging with flow
78205	Liver imaging (3D)
78206	Liver image (3d) with flow
78215	Liver and spleen imaging
78216	Liver & spleen image/flow
78220	Liver function study
78223	Hepatobiliary imaging
78230	Salivary gland imaging
78231	Serial salivary imaging
78232	Salivary gland function exam
78258	Esophageal motility study
78261	Gastric mucosa imaging
78262	Gastroesophageal reflux exam
78264	Gastric emptying study
78278	Acute GI blood loss imaging
78282	GI protein loss exam
78290	Meckel's divert exam
78291	Leveen/shunt patency exam
78299	GI nuclear procedure
78300	Bone imaging, limited area
78305	Bone imaging, multiple areas
78306	Bone imaging, whole body
78315	Bone imaging, 3 phase
78320	Bone imaging (3D)
78399	Musculoskeletal nuclear exam
78428	Cardiac shunt imaging
78445	Vascular flow imaging
78451	Ht muscle image spect, sing
78452	Ht muscle image spect, mult
78453	Ht muscle image,planar,sing
78454	Ht musc image, planar, mult
78456	Acute venous thrombus image
78457	Venous thrombosis imaging
78458	Ven thrombosis images, bilat
78459	Heart muscle imaging (PET)
78466	Heart infarct image
78468	Heart infarct image (ef)
78469	Heart infarct image (3D)
78472	Gated heart, planar, single

78473	Gated heart, multiple
78481	Heart first pass, single
78483	Heart first pass, multiple
78491	Heart image (pet), single
78492	Heart image (pet), multiple
78494	Heart image, spect
78496	Heart first pass add-on
78499	Cardiovascular nuclear exam
78580	Lung perfusion imaging
78584	Lung V/Q image single breath
78585	Lung V/Q imaging
78586	Aerosol lung image, single
78587	Aerosol lung image, multiple
78588	Perfusion lung image
78591	Vent image, 1 breath, 1 proj
78593	Vent image, 1 proj, gas
78594	Vent image, mult proj, gas
78596	Lung differential function
78599	Respiratory nuclear exam
78600	Brain image < 4 views
78601	Brain image w/flow < 4 views
78605	Brain image 4+ views
78606	Brain image w/flow 4 + views
78607	Brain imaging (3D)
78608	Brain imaging (PET)
78610	Brain flow imaging only
78630	Cerebrospinal fluid scan
78635	CSF ventriculography
78645	CSF shunt evaluation
78647	Cerebrospinal fluid scan
78650	CSF leakage imaging
78660	Nuclear exam of tear flow
78699	Nervous system nuclear exam
78700	Kidney imaging, morphol
78701	Kidney imaging with flow
78707	K flow/funct image w/o drug
78708	K flow/funct image w/drug
78709	K flow/funct image, multiple
78710	Kidney imaging (3D)
78730	Urinary bladder retention

78740	Ureteral reflux study
78761	Testicular imaging w/flow
78799	Genitourinary nuclear exam
78800	Tumor imaging, limited area
78801	Tumor imaging, mult areas
78802	Tumor imaging, whole body
78803	Tumor imaging (3D)
78804	Tumor imaging, whole body
78805	Abscess imaging, ltd area
78806	Abscess imaging, whole body
78807	Nuclear localization/abscess
78811	PET image, ltd area
78812	PET image, skull-thigh
78813	PET image, full body
78814	PET image w/ct, lmtd
78815	PET image w/ct, skull-thigh
78816	PET image w/ct, full body
78999	Nuclear diagnostic exam
91110	Gi tract capsule endoscopy
91111	Esophageal capsule endoscopy
93303	Echo transthoracic
93304	Echo transthoracic
93306	TTE w/Doppler, complete
93307	TTE w/o Doppler, complete
93308	TTE, f-up or lmtd
93320	Doppler echo exam, heart [if used in conjunction with 93303-93304]
93321	Doppler echo exam, heart [if used in conjunction with 93303, 93304, 93308]
93325	Doppler color flow add-on [if used in conjunction with 76825, 76826, 76827,76828, 93303, 93304, 93308]
93875	Extracranial study
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd, vasoreactivity study
93892	Tcd, emboli detect w/o inj
93922	Extremity study
93923	Extremity study
93924	Extremity study
93925	Lower extremity study

93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93965	Extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing
A4641	Radiopharm dx agent noc
A4642	In111 satumomab
A9500	Tc99m sestamibi
A9501	Technetium TC-99m teboroxime
A9502	Tc99m tetrofosmin
A9503	Tc99m medronate
A9504	Tc99m apcitide
A9505	TL201 thallium
A9507	In111 capromab
A9508	I131 iodobenguate, dx
A9509	Iodine I-123 sod iodide mil
A9510	Tc99m disofenin
A9512	Tc99m pertechnetate
A9516	Iodine I-123 sod iodide mic
A9521	Tc99m exametazime
A9524	I131 serum albumin, dx
A9526	Nitrogen N-13 ammonia
A9528	Iodine I-131 iodide cap, dx
A9529	I131 iodide sol, dx
A9531	I131 max 100uCi
A9532	I125 serum albumin, dx
A9536	TC99m depreotide
A9537	Tc99m mebrofenin
A9538	Tc99m pyrophosphate
A9539	Tc99m pentetate
A9540	Tc99m MAA
A9541	Tc99m sulfur colloid

A9542	In111 ibritumomab, dx
A9544	I131 tositumomab, dx
A9546	CO57/58
A9547	In111 oxyquinoline
A9548	In111 pentetate
A9550	Tc99m gluceptate
A9551	Tc99m succimer
A9552	F18 fdg
A9553	Cr51 chromate
A9554	I125 iothalamate, dx
A9555	Rb82 rubidium
A9556	Ga67 gallium
A9557	Tc99m bicisate
A9558	Xe133 xenon 10mci
A9559	Co57 cyano
A9560	Tc99m labeled rbc
A9561	Tc99m oxidronate
A9562	Tc99m mertiatide
A9566	Tc99m fanolesomab
A9567	Technetium TC-99m aerosol
A9568	Technetium tc99m arcitumomab
A9569	Technetium TC-99m auto WBC
A9570	Indium In-111 auto WBC
A9571	Indium In-111 auto platelet
A9572	Indium In-111 pentetreotide
A9576	Inj prohance multipack
A9577	Inj multihance
A9578	Inj multihance multipack
A9579	Gad-base MR contrast NOS,1ml
A9580	Sodium fluoride F-18
A9700	Echocardiography contrast
G0130	Single energy x-ray study
G0202	Screeningmammographydigital
G0204	Diagnosticmammographydigital
G0206	Diagnosticmammographydigital
G0288	Recon, CTA for surg plan
G0389	Ultrasound exam AAA screen
Q0092	Set up port xray equipment
Q9951	LOCM>=400 mg/ml iodine,1ml
Q9953	Inj Fe-based MR contrast,1ml
Q9954	Oral MR contrast, 100ml
Q9955	Inj perflexane lip micros,ml
Q9956	Inj octafluoropropane mic,ml
Q9957	Inj perflutren lip micros,ml
Q9958	HOCM <=149 mg/ml iodine, 1ml
Q9959	HOCM 150-199mg/ml iodine,1ml
Q9960	HOCM 200-249mg/ml iodine,1ml
Q9961	HOCM 250-299mg/ml iodine,1ml
Q9962	HOCM 300-349mg/ml iodine,1ml
Q9963	HOCM 350-399mg/ml iodine,1ml
Q9964	HOCM>= 400mg/ml iodine, 1ml
Q9965	LOCM 100-199mg/ml iodine,1ml
Q9966	LOCM 200-299mg/ml iodine,1ml
Q9967	LOCM 300-399mg/ml iodine,1ml
R0070	Transport portable x-ray
R0075	Transport port x-ray multipl
RADIATION THERAPY SERVICES AND SUPPLIES	
INCLUDE the following CPT and HCPCS codes:	
0073T	Delivery, comp imrt
0182T	HDR elect brachytherapy
0190T	Place intraoc radiation src
0197T	Intrafraction track motion
19296	Place po breast cath for rad
19297	Place breast cath for rad
19298	Place breast rad tube/caths
20555	Place ndl musc/tis for rt
31643	Diag bronchoscope/catheter
32553	Ins mark thor for rt perq
41019	Place needles h&n for rt
49411	Ins mark abd/pel for rt perq
55875	Transperi needle place, pros
55876	Place rt device/marker, pros
55920	Place needles pelvic for rt
57155	Insert uteri tandems/ovoids
58346	Insert heyman uteri capsule
61770	Incise skull for treatment
61796	SRS, cranial lesion simple
61797	SRS, cran les simple, addl
61798	SRS, cranial lesion complex

61799	SRS, cran les complex, addl
61800	Apply SRS headframe add-on
63620	SRS, spinal lesion
63621	SRS, spinal lesion, addl
77261	Radiation therapy planning
77262	Radiation therapy planning
77263	Radiation therapy planning
77280	Set radiation therapy field
77285	Set radiation therapy field
77290	Set radiation therapy field
77295	Set radiation therapy field
77299	Radiation therapy planning
77300	Radiation therapy dose plan
77301	Radiotherapy dose plan, imrt
77305	Teletx isodose plan simple
77310	Teletx isodose plan intermed
77315	Teletx isodose plan complex
77321	Special teletx port plan
77326	Brachytx isodose calc simp
77327	Brachytx isodose calc interm
77328	Brachytx isodose plan compl
77331	Special radiation dosimetry
77332	Radiation treatment aid(s)
77333	Radiation treatment aid(s)
77334	Radiation treatment aid(s)
77336	Radiation physics consult
77338	Design mlc device for imrt
77370	Radiation physics consult
77371	Srs, multisource
77372	Srs, linear based
77373	Sbrt delivery
77399	External radiation dosimetry
77401	Radiation treatment delivery
77402	Radiation treatment delivery
77403	Radiation treatment delivery
77404	Radiation treatment delivery
77406	Radiation treatment delivery
77407	Radiation treatment delivery
77408	Radiation treatment delivery
77409	Radiation treatment delivery

77411	Radiation treatment delivery
77412	Radiation treatment delivery
77413	Radiation treatment delivery
77414	Radiation treatment delivery
77416	Radiation treatment delivery
77417	Radiology port film(s)
77418	Radiation tx delivery, imrt
77421	Stereoscopic x-ray guidance
77422	Neutron beam tx, simple
77423	Neutron beam tx, complex
77427	Radiation tx management, x5
77431	Radiation therapy management
77432	Stereotactic radiation trmt
77435	Sbrt management
77470	Special radiation treatment
77499	Radiation therapy management
77520	Proton trmt, simple w/o comp
77522	Proton trmt, simple w/comp
77523	Proton trmt, intermediate
77525	Proton treatment, complex
77600	Hyperthermia treatment
77605	Hyperthermia treatment
77610	Hyperthermia treatment
77615	Hyperthermia treatment
77620	Hyperthermia treatment
77750	Infuse radioactive materials
77761	Apply intrcav radiat simple
77762	Apply intrcav radiat interm
77763	Apply intrcav radiat compl
77776	Apply interstit radiat simpl
77777	Apply interstit radiat inter
77778	Apply interstit radiat compl
77785	HDR brachytx, 1 channel
77786	HDR brachytx, 2-12 channel
77787	HDR brachytx over 12 chan
77789	Apply surface radiation
77790	Radiation handling
77799	Radium/radioisotope therapy
79005	Nuclear rx, oral admin
79101	Nuclear rx, iv admin

79200	Nuclear rx, intracav admin
79300	Nuclr rx, interstit colloid
79403	Hematopoietic nuclear tx
79440	Nuclear rx, intra-articular
79445	Nuclear rx, intra-arterial
79999	Nuclear medicine therapy
92974	Cath place, cardio brachytx
A9517	I131 iodide cap, rx
A9527	Iodine I-125 sodium iodide
A9530	I131 iodide sol, rx
A9543	Y90 ibritumomab, rx
A9545	I131 tositumomab, rx
A9563	P32 Na phosphate
A9564	P32 chromic phosphate
A9600	Sr89 strontium
A9604	Sm 153 lexidronam
A9699	Radiopharm rx agent noc
C1716	Brachytx, non-str, Gold-198
C1717	Brachytx, non-str,HDR Ir-192
C1719	Brachytx, NS, Non-HDRIr-192
C2616	Brachytx, non-str,Yttrium-90
C2634	Brachytx, non-str, HA, I-125
C2635	Brachytx, non-str, HA, P-103
C2636	Brachy linear, non-str,P-103
C2638	Brachytx, stranded, I-125
C2639	Brachytx,non-stranded,I-125
C2640	Brachytx, stranded, P-103
C2641	Brachytx, non-stranded,P-103
C2642	Brachytx, stranded, C-131
C2643	Brachytx, non-stranded,C-131
C2698	Brachytx, stranded, NOS
C2699	Brachytx, non-stranded, NOS
G0173	Linear acc stereo radsur com
G0251	Linear acc based stero radio
G0339	Robot lin-radsurg com, first
G0340	Robt lin-radsurg fractx 2-5
Q3001	Brachytherapy Radioelements
EPO AND OTHER DIALYSIS-RELATED DRUGS	
The physician self-referral prohibition does not apply to the following codes for EPO and other dialysis-related drugs furnished in or by an ESRD facility if the conditions in §411.355(g) are satisfied:	
J0630	Calcitonin salmon injection
J0636	Inj calcitriol per 0.1 mcg
J0882	Darbepoetin alfa, esrd use
J0895	Deferoxamine mesylate inj
J1270	Injection, doxercalciferol
J1750	Inj iron dextran
J1756	Iron sucrose injection
J1955	Inj levocarnitine per 1 gm
J2501	Paricalcitol
J2916	Na ferric gluconate complex
J2993	Reteplase injection
J2995	Inj streptokinase /250000 IU
J2997	Alteplase recombinant
J3364	Urokinase 5000 IU injection
P9041	Albumin (human),5%, 50ml
P9045	Albumin (human), 5%, 250ml
P9046	Albumin (human), 25%, 20ml
P9047	Albumin (human), 25%, 50ml
Q0139	Ferumoxytol, esrd use
Q4081	Epoetin alfa, 100 units ESRD
PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES	
The physician self-referral prohibition does not apply to the following tests if they are performed for screening purposes and satisfy the conditions in §411.355(h):	
77052	Comp screen mammogram add-on
77057	Mammogram, screening
80061	Lipid panel [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
82270	Occult blood, feces
82465	Assay, bld/serum cholesterol [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
82947	Assay, glucose, blood quant [only when billed with ICD-9-CM code V77.1]
82950	Glucose test [only when billed with ICD-9-CM code V77.1]
82951	Glucose tolerance test (GTT) [only when billed with ICD-9-CM code V77.1]
83718	Assay of lipoprotein [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
84478	Assay of triglycerides [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
G0103	PSA screening

G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0202	Screeningmammographydigital
G0328	Fecal blood scrn immunoassay
G0389	Ultrasound exam AAA screen
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys
The physician self-referral prohibition does not apply to the following immunization and vaccine codes if they satisfy the conditions in §411.355(h):	
90655	Flu vaccine no preserv 6-35m
90656	Flu vaccine no preserv 3 & >
90657	Flu vaccine, 3 yrs, im
90658	Flu vaccine, 3 yrs & >, im
90660	Flu vaccine, nasal
90669	Pneumococcal vacc, 7 val im
90732	Pneumococcal vaccine
90740	Hepb vacc, ill pat 3 dose im
90743	Hep b vacc, adol, 2 dose, im
90744	Hepb vacc ped/adol 3 dose im
90746	Hep b vaccine, adult, im
90747	Hepb vacc, ill pat 4 dose im

[1] CPT codes and descriptions only are copyright 2009 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.

[2] This list does not include codes for the following designated health service (DHS) categories: durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. For the definitions of these DHS categories, refer to §411.351. For more information, refer to the CMS Web site at http://www.cms.hhs.gov/PhysicianSelfReferral/.

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